# MEDICARE PAYMENT ADVISORY COMMISSION

## PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

**Thursday, October 18, 2001**
**10:05 a.m.***

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

* *October 19 proceedings begin on page 241*

AGENDA PAGE

Quality improvement for health plans and providers (November 2001 report) -- Karen Milgate, Mary Mazanec 3

What next for Medicare+Choice? -- Scott Harrison 46

Consumer coalitions in Medicare (December 2001 report) -- Susanne Seagrave, Scott Harrison 85

Public comment 105

Payment for outpatient pain management procedures (December 2001 report) -- Penny Mohr, Senior Research Director, The Project HOPE Center for Health Affairs, Nancy Ray, Kevin Hayes 117

Assessing payment adequacy -- Jack Ashby 159

Updating Medicare payments -- Nancy Ray, Jack Ashby 190

Payment for physician services -- Kevin Hayes 202

Public comment 230

***NOTE: October 19 proceedings begin on page 241***

P R O C E E D I N G S

MR. HACKBARTH: Could I ask people in the back of the room to take a seat, please? Karen and Mary, I think the best way for us to get people focused and seated is to actually start with your presentation. So why don't you go ahead and I think people will quickly fall in line.

MS. MILGATE:

For the next hour or so we're going to be talking about the question of how Medicare should apply quality improvement standards to the Medicare+Choice and the fee-for-service program. This is, in fact, one of the tools that CMS and Congress have to take what Dr. Berenson described this morning as a step-by-step approach, in fact, to Medicare potentially leading in the area of quality improvement.

In answering the question, Congress asked MedPAC to consider the feasibility of applying standards that are comparable to the Medicare+Choice quality improvement standards to all types of providers and plans. So that's really the centerpiece of the analysis that MedPAC staff have begun so far.

This request was included in the Balanced Budget

Requirement Act of 1999 in response to the controversy over how to apply Medicare+Choice quality improvement standards to all types of plans in the Medicare program.

In the BBA, Congress enacted the Medicare+Choice program and applied quality improvement standards to all plans, but recognizing that these standards did represent a more rigorous approach to quality regulation, they thought it might be difficult for some types of Medicare+Choice plans to meet those requirements. So they exempted non-network MSA plans and private fee-for-service plans from a portion of the requirements that required plans to actually demonstrate improvement.

And then they went ahead two years later in the BBRA to exempt PPOs from those same requirements. So this created the unlevel playing field between Medicare+Choice plans and it was unlevel from two perspectives really, from the PPO or non-HMO perspective it was unlevel because for them to meet the standards it was difficult, if not impossible, some of them suggest, and very expensive and didn't recognize, they argued, the value they bring to consumers which is really a broad choice of network.

For HMOs, they considered the playing field

unlevel because they had to put out resources to meet a higher level of standards but they weren't playing any more for putting those resources in place, so they argued this gave them a market disadvantage that perhaps they wouldn't be able to, for example, provide as rich of a benefit package as the non-HMOs might be able to provide.

Both plan types, however, agreed that this created an unlevel playing field between programs. They argued that the requirements in Medicare+Choice were more rigorous than those applied in the fee-for-service program. And we'll talk just a little bit later on some comparison between the two programs, as to see whether that is, in fact, true or not.

To help answer the question and to address the issue, MedPAC staff has interviewed numerous purchasers, different types of providers, various types of plans, accreditors, state regulators, and of course, talked extensively to CMS personnel to understand more about the Medicare+Choice standards themselves.

We've put in your meeting materials, under Tab C, three background pieces that are the results of this research and talking to various officials that do two

things. One, it identifies the goals of quality improvement and then the various ways to apply quality improvement standards. That's your background paper one.

And then we analyzed the Medicare+Choice standards and the fee-for-service quality improvement efforts, which are background paper two and three, to really get a sense of the current regulatory environment to compare quality improvement efforts across the programs, and then to identify some of the problems with applying Medicare+Choice-like standards to different types of plans and providers.

Using this information what we learned about the provider and plan ability to actually perform quality improvement, we then evaluated the feasibility of applying Medicare+Choice-like standards to each type of provider and plan.

So what is the goal of quality improvement standards? Broadly speaking, the goal is to close the gap between what we know to be good care and the actual care that's delivered to patients. We know that in many clinical areas there are well accepted and well known ways to deliver care that do not always reach the bedside.

One example that illustrates this is beta blockers

after heart attack. It's well known that if a patient does receive beta blockers after they've had an initial heart attack that it can often prevent another heart attack from occurring. But in data that was released from the PRO program last fall, it showed that the median rate for patients being discharged with a prescription of beta blockers was 72 percent. Meaning that 28 percent of the patients, in fact, sort of lost a chance to get a prescription for something that could have prevented a heart attack from occurring in the future.

In addition to problems in specific clinical areas, there is also growing concern over the prevalence of medical errors which affect all types of patients. The IOM report that was released a couple of years ago documented this gap in quality and talked about steps to perhaps solve that issue as well.

So what do quality improvement standards require organizations to do that actually help us move toward that goal of closing the gap? There's really three steps, as we talked to various types of organizations that try to implement quality improvement standards.

The first is to establish systems to measure the

quality of care, then to use the information about the problem that they may have identified to put in place interventions that will influence either the system or clinician behavior. And then thirdly, and this is really the new piece of the standard that's different, in essence, than the more regulatory approach to quality improvement. And that is to actually demonstrate the results of what they do to a third party. Sometimes this takes the form of the requirement that you show you've actually improved on something. Other times, because the regulators or oversight agencies aren't as clear about whether you could improve or the level of improvement, it merely requires the organization to report in the results of their measurements.

Questions arise in this area about how meaningful the data are. For example, if sample sizes are not large enough maybe they don't really tell you anything significant about the organization. And there's also always the question of how possible it is for the organization you're holding accountable to really change behavior on whatever you're measuring them on.

The Medicare+Choice quality improvement standards really have two parts. The first is they are required to

establish a quality assessment and performance improvement program. This includes standards like putting in place an appropriate information system for collecting data. Often the source of data would be either claims, looking at claims, abstracting information from medical records or surveys, having the appropriately trained personnel, making sure you get the right input. For example, the QA/QI standards require organizations to have appropriate input from enrollees and clinicians.

And then also, they're very specific about the types of criteria that you need to use for choosing projects to work on and how you analyze your effectiveness on this project.

They require that organizations demonstrate the results of their efforts by reporting on two QAPI projects. On these projects, CMS requires plans to actually show improvement. When they began, when they put these regulations in place, at first they had a 10 percent minimum requirement. CMS has since backed off on that because of concerns that, in fact, they really didn't know why they had chosen 10 percent. It was unclear that that was really a good goal. It was also unclear, for some plans, whether

they could actually reach that given that the criteria and the sophistication of the QAPI projects were beyond many plans who had not measured things at this level before.

Secondly, they have to report on HEDIS Medicare measures. This is an example of building on private sector efforts. For those plans that are experienced with NCQA accreditation, these types of measures are very familiar to them. For plans that aren't familiar with NCQA accreditation, this was a whole new level of infrastructure for them to have to create.

However, they are not required to show improvement on these measures. They simply have to report. The assumption is that if they measure what's going on in these areas that they will do something to improve upon their performance in those measures.

The third piece is CAHPS, the Consumer Assessment of Health Plans Survey, which is actually administered directly to beneficiaries by CMS. So it really adds no extra cost to the plans. This is really a look at beneficiary perception of both the plan and the providers within the plan. Questions like how good do you think your care is? Is this the best plan? Or is it not as good as

you would like? Waiting times, how available providers are, getting at some issues you had talked about earlier, Allen.

Non-HMOs are exempt from the two QAPI projects. That's really the regulatory extension of the exemption that was in legislation from demonstrating improvement. So they do not have to do those projects or show improvement, obviously, on those projects.

Plans have told us about a variety of different problems they have with how these are implemented. They, I think, can be categorized in two broad areas. One is they think that they represent stretch goals. That essentially these are not bad QI efforts, but question whether it's reasonable for a regulator to actually be putting these types of stretch goals in place as requirements.

Secondly, they feel like there's a lot of duplication, both at the standards level as well as the reporting requirements level, between what CMS is requiring and what other oversight bodies require and don't think it's necessary that this duplication exists. They don't think there's enough extra quality improvement achieved by simply some other requirements being placed on them.

In the fee-for-service program, the quality

improvement efforts really operate at two levels. When we say plan level, we're talking about essentially CMS in the role of administrator of a benefit package for the Medicare beneficiaries. What they do to put in place the infrastructure that's required in Medicare+Choice plans is basically to use the PRO program as their infrastructure to measure quality of care, as well as to improve the quality of care. They do do some independent analysis of claims data, but the PROs do the medical record abstraction and then are really the foot soldiers on the ground to work with different types of providers, plans, and even beneficiaries to try to improve the care that's delivered to Medicare beneficiaries.

For example, beneficiaries, they tried to influence them directly in the area of immunizations, recognizing that the demand for immunizations is one important factor in improving on that particular measure.

They report on the results of their effort through -- on the PRO measures, there are six focus areas and they report publicly on those. They also use a fee-for-service version of CAHPS. And then are trying to develop the ability to compare between fee-for-service program and the

Medicare+Choice program in various areas by reporting on some HEDIS measures that would overlap with the PRO measures.

At the provider level, there really are a lot of voluntary efforts, but few requirements at present. Many providers are accredited and often by the Joint Commission, which does require that institutions have in place quality improvement processes. They also work voluntarily and increasingly so with the PRO program to improve care in certain areas. And then of course, providers have some of their own initiatives that aren't associated with external efforts.

CMS has tried to put in place some requirements through the conditions of participation for various institutions to establish quality improvement programs and those eventually will come out in final form. But as of yet, they have not been finalized.

They also are talking about, and this is probably the most significant discussion occurring in CMS right now, about how to use reporting requirements on various institutions to stimulate quality improvement within those organizations. They do require some reporting on measures

for home health agencies, nursing homes, and dialysis facilities but they're thinking about how they might expand those efforts to encourage and stimulate quality improvement.

So given what we know about Medicare+Choice standards -- actually, let me call your attention to the chart that we placed in front of you. It was in your meeting materials, but a larger version we placed in front of you before the presentation, because this is really the guts of the analysis.

Given what we know about Medicare+Choice standards and what we know about how plans and providers can actually perform quality improvement, we asked two questions. The first question is how capable or how feasible is it for different plan types and providers to actually meet Medicare+Choice-like standards? And once we get a sense of how difficult or easy it is for those types of plans or providers to meet those standards, could we actually hold them accountable for meeting those standards?

So just to look at the Medicare+Choice HMOs, many of them do have the infrastructure to measure the quality of care and to influence behavior of providers and clinicians

to improve their care. This is true for many, but not all. There are small plans that don't have that capacity. There are plans that are not familiar with accreditation, and so it is a whole new infrastructure for them.

Can they demonstrate the results? Generally, their results would be valid. They usually have broad enough populations, although once again with small plans that would not be the case.

So could they be held accountable? Clearly, they could be. The question here, as we've talked to various plans and CMS, is really whether the current level of effort is necessary to achieve the extra quality improvement that may be achieved by placing these standards on HMOs, and if there are ways possibly to lessen the burden on how the M+C standards are applied.

For non-HMOs, it really varies as to whether they are able to measure the quality of their care. Those that are affiliated with HMOs, meaning they may be offered by a plan that has an HMO as well, oftentimes do have the infrastructure to measure what they're doing. However, they told us that even if they have that infrastructure, it's very difficult to apply it.

There's really three factors that are important here. They have much broader networks than HMOs usually. They don't require beneficiaries to choose primary care physicians. And they also allow beneficiaries oftentimes to go out of network. So this causes problems both for measuring and improving. Essentially, they don't know where to go to get the information. It's very difficult, at least. They don't have a primary care physician to look in the medical record for some services to see if the service was provided. There's many different places they could go.

This also makes it difficult for them to focus their improvement efforts. They also have some many different clinicians that they need to influence they don't know really which the right one is. And so, it's very difficult for them to apply an infrastructure even if they have it.

In terms of them demonstrating their results, they often do have a broad population. But clearly, if the data you collect are not accurate, it's not going to be very useful for measuring you.

They do, however, have fairly good capacity to measure care on measures that rely on claims data. So

that's one thing to keep in mind. It's very difficult for them to go into medical records, but they do have good claims data. So they could be held accountable.

It appears that it would be very difficult to hold them accountable to the same level as the HMO without really demanding that they change their structure from a PPO or broad network structure to a tighter network. However, there may be ways to assist them in measuring their quality or helping them put in place interventions. And it might be possible to hold them accountable for different measures, particularly ones that are based on claims.

For the fee-for-service program, as a plan, they do have the infrastructure to measure. They have pretty good capacity and mechanisms to influence the behavior of providers. They could perhaps use that even more than they do. They don't currently require providers to participate in the PRO program, for example. And their statistics are valid. We don't really know the results of the current voluntary efforts, so it's hard to know whether any higher level of accountability would be useful or not.

For institutions and clinicians, the answer really varies by size. Some are more sophisticated than others.

However, the biggest difficulty is really finding measures that are useful for comparison. So you could perhaps require some process or some participation with other efforts, but it would be difficult to use the same measures.

In summary, all plans and providers do seem to have some capacity to measure improved quality of care, however the cost of meeting the Medicare+Choice-like standards is really unequal across plan types and providers. But strategies do exist to reduce those costs and to move towards the goal of improved care for Medicare beneficiaries.

That concludes my presentation. I would be glad for any questions and, in particular, comments on the direction of our analysis and any comments specifically on how to apply quality improvement standards to different plans and providers.

MR. HACKBARTH: Let me just first welcome our guests now that everybody is in their seats. Thank you all for coming and we appreciate your interest in our work. As in the past, there will be a public comment period at the end of the day. Those of you who have a contribution to make will have a chance to offer that to the Commission. Or

even at the end of the morning, I'm reminded. So it's scheduled at 12:30 and that will be the first comment period.

Thoughts about Karen's presentation?

DR. NEWHOUSE: First in the way of disclosure. I should say to people that I was elected a director of Aetna in late September. So I hope that won't much affect what I say here, but people should know that.

I should say, speaking personally, I found this a really hard issue. In some sense, the hardest issue, I thought, of the mix on our platter here. I had a few thoughts about it. One was a thought that has come up earlier, which is to distinguish standardization of measurement and information tools from trying to standardize actual care delivery and regulations directed at that. I think we've done a somewhat mixed, but on the whole pretty good record there.

Second, my general bias is for what I'll call within sites of care, to try to decentralize the regulation and try to use deeming as much as possible.

The third thought is that M+C plans, especially those, which I think are most of them, that use non-

exclusive contracts are likely to be too small to do very much in many cases. So it's kind of pointless to hold them responsible. They just don't have the leverage.

MR. HACKBARTH: Joe, too small in terms of having too small a share of the patient volume with an individual provider?

DR. NEWHOUSE: Yes, too small a market share.

The fourth thought, the last one, is that in terms of thinking about M+C plans and HMOs and maybe this applies to PPOs, too. It seems to me where their largest value added is is likely to be on the coordination function. We know that there's lots of quality problems that arise in handoffs from one site of care to another site of care. The traditional plan, it seems to me, mostly relies on the PCP to watch over this handoff. The HMO actually kind of sits there above this in a way that there's no analog for on the fee-for-service plan, could conceivably do something here.

It seems to me it makes more sense to think about a role for the HMO in that domain than it does to say improve beta blockers after heart attacks, where you could go down to either an accreditation agency or you could have the PRO at the local level working on that, rather than say

this is the HMO's responsibility.

MS. BURKE: Actually this is very consistent with what Joe has suggested with perhaps the following slight deviation. I think, in fact, because it is so complicated for non-HMO plans and for plans with smaller volumes to understand how it is, in fact, they might control the outcome, it is incumbent upon us, I think, to help them identify the tools that might be available to them and how they might, in fact, begin to influence this behavior.

I think there is going to be a growing number of people potentially who choose those options. And to simply give up on efforts to have them play a very major role in trying to both track, as well as influence behavior that has an impact on quality, would be to leave outside of this a fairly sizeable portion of the Medicare population.

So I would hope as you go through -- and I found the chart to be quite useful. I thought you did quite a nice job of laying out for us the sort of array of issues that exist, depending on the structure of the plan. I think some emphasis on those that fall outside of the traditional HMOs, that do have the tools available more readily, and focusing on the traditional fee-for-service and the sort of

non-HMOs in looking for how they might team up, looking for tools they might have available, looking for ways that we can, in fact, assist them in identifying methods of influencing this is time well spent for us. I think we can't simply give up on that and turn simply to the HMO structure and assume that will be the only solution.

DR. ROWE: I'd like to ask Sheila a question, if I can. I was surprised to hear you say it's a substantial portion of the Medicare population. The whole M+C program is 4.5 million members now. The non-HMO piece would be how many members?

MR. HACKBARTH: It rounds to zero.

MS. BURKE: Right. My reference was really in the broader context, Jack, not just to the M+C but rather the fee-for-service and all the other sort of models.

DR. ROWE: Thank you, that clarifies, because I think focusing on the non-HMO piece of this is almost not worth the type here.

MS. BURKE: My point is those outside of a traditional M+C HMO in the rest of the program are the large majority, and that we ought to look for tools to assist across the board, was my point.

MS. NEWPORT: I think Sheila is right in terms of the tools. Even in what we look at as a company, where we may be a small part of the market geographically literally, what we're trying to do is have some quality programs and disease management programs that, by raising the bar for a portion of the patient base, we raise the bar for the rest of the patient base, too. It does have an influence.

And we are trying to identify and make public our own quality measures of provider group activity, and therefore steer patients to groups. Now large multi-specialty provider groups find it much easier to participate in these programs, but I think that the bar needs to be raised and tools can be segmented differently.

I appreciate very much, I think you captured the scope of the problem and the difficulty in trying to be too granular here, in terms of the offset, loss of productivity or increased costs. And having been subjected to my own medical director's four-and-a-half long dissertation on how we measure quality -- and they are paid to do that, by the way -- it is a difficult program.

I would hope though that people would appreciate that there were some howls, very loud ones, about CMS's --

then HCFA's -- programs on quality assurance. I wanted to be clear that the problems were with chancing horses in midstream, literally. We would have disease management protocols that had been put in place because of our intent to be NCQA certified, which is a very intensive process, only to see things that are iterative and need to grow over time be supplanted by something else that we weren't doing.

There were certain disease management, diabetes being a very critical one. And then the next year there was going to be a whole class of other four disease management programs that you had to do.

So I think it's very important to have focus on continuity and consistency and achievable measures. A 10 percent improvement every year, when you're meeting a quality of index of 92 percent, the last gasp that you have to reach for, the bridge too far literally, is diverting resources from some other program that might benefit from a 2 percent incremental improvement over time, or those areas where you needed to go 20 percent because the indices were so low.

So again, I compliment you on the breadth of your analysis. I think you've captured the problem. I think

some refinements in making reasonable tools available and incentive to the program that might -- and I mean from quality competition -- might bring providers along even subtly in terms of the effect you can have in patterns of practice in a marketplace -- if I can be bold enough to use marketplace in this instance.

I do think that there are ways that you can do that, and that we're seeking to reward better quality performance as much as anything else in terms of a provider's ability to get a full panel of patients.

DR. NELSON: I also thought that you did very nice work with respect to these papers. I want to make just three points and it's largely from the standpoint of clinicians rather than plans.

The first is to again point out the distinction, to some degree the mutual exclusivity, between quality assurance and quality improvement. The Commission has dealt with that distinction in previous reports, but I think it's always useful when we're talking about quality standards to point out that one is sort of externally applied and has more of a regulatory impact, and that quality improvement,

on the other hand, depends on a different set of assumptions.

The PRO program, for example, has struggled with these competing requirements throughout the last 10 years. The Joint Commission as well has certain quality assurance minimum standards, but then also to try and encourage introspection and self-examination and team application of quality improvement efforts. And it's still struggling. But to reference that distinction again is useful, even though we've dealt with it before.

The second point is to underscore the difficulty in getting data from the outpatient clinical record. We've done some work 25 years ago in Utah in having trained nurse auditors go into the physician's office and sit in the waiting room, in some instances, or back in an examining room in other instances, and try and abstract data for quality assessment. If nothing else, it's extraordinarily expensive and burdensome and difficult. You make the point, but I want to underscore it.

I think it's worth pointing out that one of the reasons for that is that the clinical record was developed for a different purpose. It wasn't developed for purposes

of accountability. It's a tool that clinicians use to aid in patient care. Even though increasing use of a problem list and flow sheets and so forth make some data collection easier than it used to be, still it's extraordinarily difficult.

At ASIM we did some work in simple measures, like hemoglobin A1Cs for diabetes and monitoring the anticoagulation status in patients on warfarin, and so forth. Even with volunteer physicians signing up to do this and following relatively simple protocols, it took an enormous amount of work and dedication. They'd stay late at night and try and find the bloody records and get the information from the records. Until there is a widespread adoption of a new kind of recordkeeping that employs an electronic medical record, it isn't going to get any easier.

So the practical application of some of these rules needs to be underscored.

The third point that I want to make is that it's probably worth acknowledging that the specialty boards are moving rapidly into performance measurement as part of their recertification processes. Of course, it's being met with a certain amount of skepticism and, to some degree, anguish

because of the difficulty in getting information from the medical record. But I think that the commitment isn't going to go away, that the recognition of public expectation is going to continue.

It may be worth including some reference to that level of activity. Because at some point, that may provide a solution with a deeming and private sector activities that the Medicare program can simply ride on board.

DR. ROWE: Just a couple general comments. I think I'd like to associate myself with Janet's remarks, from the point of view of another health plan that participates in the program.

I would note that I think that CMS has been responsive and is mindful of the burden. They have, I think, dropped that 10 percent requirement of an annual increase, mindful that the last 2 percent is different from the first 10 percent in costs and feasibility, et cetera.

I think that the general discussion is very good. I would suggest that you drop out the non-HMOs. If you look at the table and if you read the material, just given that it's a rounding error or it rounds to zero, it's really not -- we need to focus on the important piece of this, I think.

You might have it there as a section at the end, that this is a very small program and it's different. It's not a big deal, but someone not knowing a lot about this and looking through this, you don't get a sense of the relative proportions here. Maybe you could include those data somewhere, in terms of relative proportions, how many Medicare beneficiaries are represented or something like that.

I guess the most important comment, or the comment I'd like to emphasize, is that I think in the overall Medicare+Choice program -- let's step back a bit -- there has been some disappointment that there has not been a modification of the funding amounts or mechanisms. There's been some, but I think most people think modest withdrawals recently, compared to what was expected. But they are likely to continue if there's not a change.

There's been discussion from CMS that yes, we can't give you anymore money, but we can help you on the regulatory side. We could try to reduce regulation that might be burdensome or costly, directly or indirectly. We don't want to add more barriers to participation in the program.

I think that that is what I've heard, at least, and I think that that's well received.

One might look at this issue from that point of view and say we don't want to back off completely from issues of quality. I think that would send the absolute wrong message. That would be just stupid to say well, we're going to help them on the regulatory rather than financial side, so forget these quality measures. That's not what managed care is about fundamentally, I believe, and that would be an atrocity. Nobody wants to go there.

But to whatever extent we can make the requirements here concordant with the form and the substance with the requirements that the health plans have with NCQA or in other things, so that we don't have two different mechanisms and two different kinds of data, then that reduces the burden financially and in other ways, and gets us to a standard which is generalizable to some extent.

So I think that would be a kind of principle that I think is worth applying to this while maintaining a focus on quality.

MS. RAPHAEL: I wanted to address the part that had to do with the fee-for-service side and some of the

issues that exist there. First of all, I was very interested in some of what you wrote, although I think it needs to be expanded on, on the extent to which you can use conditions of participation more vigorously. I think there are issues about easy entry. And right now, there's very easy entry. I would like to have more thinking around whether or not that ought to be changed and whether there's more that can be done at that level.

I know in the home health care field there was a point where practically anyone could enter the home health care field. There were people who had jewelry stores during the day and then changed the sign in the afternoon and became home health care providers at two p.m. And I think some of that has been rescinded in the last few years. But I think that whole issue of entry needs to be looked into.

I've often been told don't enter into anything that you can't exit from. And I think the whole issue of exit, too. And I think the point is made that almost no one ever exits the program except voluntary. I think I'd like to better understand the whole issue of the kind of mechanism of exit and how it works or doesn't work effectively in the fee-for-service program.

I am not as taken with the issues of reporting. I recognize all the issues about the necessity to have valid and credible data. But I think the greatest challenge isn't that, because we're getting a tremendous amount of data now. I think the greatest challenge is how do you change behavior at the clinician level, where you -- in this what I thought was well done effort here -- indicate that clinicians have the greatest ability to influence clinical quality except it's too much of a burden for them often to collect, and they can't get valid results on an individual level.

To me that's sort of the crux of this. I mean, how can we influence what happens at the clinician level? I think we have to think about how we're going to work at that level, not only at the organizational level and the health plan level. And that is very difficult to do.

We're engaged in a major project now on changing wound care practice. 20 percent of our admissions have wounds, a variety of wounds. And how you change how every practitioner handles the wounds is very complicated because you have to interact with physicians who are using treatments that may be 20 years old or that they learned in medical school. There are many new advances. It's not just

a matter of how you report on it. The hardest part is how do you really get results and demonstrate improvements?

I also think there needs to be some looking at this issue of collecting data for payment systems and then using it for quality. I have some experience with that where we're doing this massive dump, sending in all this OASIS data which we use for payment. And then it's supposedly going to be used for quality.

I'm not sure that that's going to work very well. I think it raises other issues. I think it does heighten awareness about, for example, a high level of emergency use. But then, when you see CHF patients going back to the emergency room in one out of three cases, you ask yourself does that indicate too early discharge? Does it indicate inadequate follow up by the physician? Or have we, in some way, not done what we should do? So I think that that is another issue that needs to be looked at.

And then lastly, I think there is a lack of incentives in the whole payment structure for good quality. Quality can save money because if you do things well you don't have to do them three times. And anyone who's dissatisfied costs you a lot of organizational energy. But

also, to put in the infrastructure and have the tools also costs money. And I don't think the incentives are aligned now to really support what everyone says is really vital.

DR. WAKEFIELD: I want to just start by agreeing with Joe. I thought this area of focus was awfully difficult. When I was reading through it, and I do a little bit of work in quality, I really appreciate the challenge that you have.

I think the question for me was should all of M+C be subjected to quality measurement for the purposes of accountability? In an ideal word the answer, from my perspective, would be yes and there would be comparability.

I might even step back from that, and my comments are pretty general regrettably, but I might even step back from that and say should the entire Medicare program be subjected to quality measurement? And should there be comparability and similarity where it can occur across those measures? And I think the answer to that would be yes.

The tough part is coming up with the approaches about how to get there.

Some of what I think is coming out of the National Quality Forum might be relevant, and you've taken a look at

it obviously because you've cited it in your work, in terms of some guiding principles. I'd comment a little bit on some of what Dave had to say and then my own views.

One, there's measurement for accountability and measurement for improvement. Sometimes those two things are distinguished. But clearly, I think there needs to be some overlap. Those purposes should be mutually reinforcing.

And improvement, quality improvement, is often motivated by external accountability. And some of your content suggests that that's the case, that we get improvement when entities are required to be accountable to some external entity. Whether that's CMS through the PROs reporting to them, or it's broader public disclosure, wherever along that continuum.

The point, though, that I think accompanies that is accountability measures are really only effective, from my perspective, if they relate to improvement measures that plans or providers can actually take action on. Is it in the M+C's ability to do something about whatever X is? Are they truly able to exert influence in a particular area? So when we're thinking about accountability, it's accountability for what and is it within their scope to be

able to exert influence?

I also think ideally that data, when we're collecting data -- and this theme comes through I think a little bit in your writing -- data should be collected once. An organization should be asked to collect it once. I think, typically that data should be collected as close to the point of the care being provided as possible. And to the extent we can, we reduce the burden on providers in obtaining that data. And that we ensure that we're constantly filtering to make sure that the data are relevant to patient care ultimately, that it's useful.

And we've talked a lot about the burden of data collection on providers. But I also think there's another burden. And that is whether we're asking for the collection of data that's not directly useful to the entity that has to collect it. So it's yes, there's a burden associated sometimes with the collection of data, but there's sure a burden associated with it if they're going through the motions of collecting information that's frankly not relevant. What are they going to do with it once they get it?

I think, to the extent we can encourage plans to

not have to report in multiple, incompatible ways, across private sector and public requirements, to beat some efficiency into this system, it seems to me would be a guiding principle we ought to be thinking about.

The last point I would make is that, in general, you made the point about volume of services and that an event needs to happen often enough for a meaningful measurement. I think we all know that.

So should we be thinking about making a comment about how data, when they can be, should be rolled up and aggregated to a level of aggregation that's relevant and valid? For example, I can imagine detailed data that's relevant for quality improvement. So you might collect information on beta blocker performance. That's just used internally across some subset of providers.

That same data will be invalid for cross-provider comparisons. So data collection might be appropriate at one level but not another. But if we had some, over time, appropriate investment of measurement methodology and research, over time we might be able to find ways to aggregate and collect information and make it meaningful at multiple levels.

But right now, just because it's not relevant at one level may not render it irrelevant at another level. So there's a point.

I think that's it, just some general comments.

MR. HACKBARTH: As I look at the overall framework that we have, it seems one of the guiding policy objectives is to offer Medicare beneficiaries a range of choices in the program and a variety of others, ranging from private fee-for-service to MSAs to PPOs to HMOs.

A concern that I have is that imposing a single set of requirements for quality improvement on what are diverse systems and capabilities by definition, will frustrate the goal of choice. The capabilities of these organizations are different, and to have a uniform set of expectations, I think, is going to lead to frustration and -- at least in the case of many organizations -- departure if that's a feasible option for them, exit.

One of the questions we were asked by the Congress is should the same requirements that are imposed on HMOs be imposed on everybody else and level up, if you will, to that level. To me, I think that's a course that's full of risk because not all organizations are organized the same way,

have the same capabilities.

Instead, I would be more inclined to say if we want a uniform approach, what we ought to do is a level more at the approach now being taken in the fee-for-service Medicare program, as I understand it, which emphasizes voluntary quality improvement efforts. That's not to endorse the specifics of what are being done, but the general approach.

What I would like to see us expand on perhaps is the way that we try to reward and encourage and support those voluntary quality improvement efforts, so that there is actually a reason for people to want to do it beyond the fact that they're committed to trying to do the best for their patients. It could be financial, as Carol pointed out. It could be in terms of information disclosure, quality scores or measures of some sort. It could be a seal of approval as provided by accreditation that is then marketed, if you will, to Medicare beneficiaries that certain organizations have invested more and they have different capabilities than others.

Some might say that emphasizing voluntary and rewards and encouragement is to weak, given what some people

-- I guess the IOM -- characterize as a chasm between what we know about proper medical practice and what, in fact, happens every day. Like Jack, I think we should not be considering backing away from efforts to improve quality. It's not the end that's in question but rather the means.

But I think we have to be realistic about what we know about quality improvement. We have to be realistic about the capabilities that people have to do quality improvement at this point in time, and to be realistic about the costs involved. And we need to walk before we run.

I think the surest way to give all of this a bad name and spawn a terrible reaction to it is if we tried to do more than we can given our knowledge and our resources.

So I would like to reward voluntary efforts as aggressively as we can figure out how, but let's not level up and impose unrealistic requirements across the board in the name of equity or uniformity or an even competitive field.

MR. FEEZOR: Glenn, following up on your comments, I've sort of changed some of the things that I was going to say. But let me just say, and we'll come back to this a little later in the day, I think the choice is largely -- at

least from my post in California, in watching the market for both over-65 and under-65 that I try to serve -- that choice is more of a political construct. What our beneficiaries really want is value and security and they have a way of measuring that very fast.

I agree, Glenn, with your comments that it is fraught with difficulty to try to level up to the M+C plan level. And yet, I don't think -- I guess I agree with Sheila that given at least the retreat in terms of the M+C plan from servicing a larger number, that we have to keep pressure on those other entities, keeping in mind Jack's reservation about overemphasizing what the non-M+C plans represent.

My bet is, though, that if we looked in the Medicare supp world that we tend to forget, that almost all of those vendors use some of network. Presumably, they use some sort of credentialing and some sort of profiling and some sort of capturing of data to, in fact, evaluate that. Admittedly, most of it based on cost. So I do think we need to keep the pressure on, though I think leveling it up, as you said, is going to be very, very difficult and unrealistic and does impose burdens on precisely those

entities that at this point in time many of our beneficiaries indicate they won't. Though I think they want more the value and security that's with that, as opposed necessarily to those entities themselves.

The final thing, and this is what we're struggling with in California again, as Janet may attest, we perhaps are somewhat unique and we have a couple of our biggest players are so heavily into capitated arrangement with delegated responsibilities. But it does drive home to me that the one common denominator is, in fact, the provider and the provider system that serves all of our beneficiaries. And to the extent that the accountability and the capturing, at least, of information that's helpful in evaluating quality at some level or quality improvement efforts, that we would be wise to think more of what is the true common denominator, as burdensome as that may be to the provider side.

DR. REISCHAUER: I have a general observation, a question, and a comment. The general observation, it's almost un-American to be skeptical about quality and quality improvement, but I'm very skeptical about this whole effort. Maybe it's because I read this material late at night and

therefore find it even though to master than Joe does, but we're having a hard time defining exactly what it is. Even if we could agree on the definitions, we have a hard time measuring it. And if we could measure it, we're not sure that the beneficiary could interpret the information correctly.

Just as an example, when you're thinking of fee-for-service versus Medicare+Choice and you might have a measure that says 80 percent of women in Medicare+Choice get an annual mammogram and only 50 percent doe in fee-for-service. I don't know if that's true or not. This might be interpreted by people as saying if I join a plan, they won't let 20 percent of the people get mammograms, as opposed to fee-for-service I know I'm in control and I'm a responsible person. So of course, I'll be part of the 50 percent. And so what is otherwise useful information turns out to skew decisions in exactly the wrong way.

My question is how sure are we that this effort at quality improvement really is leading to an aggregate improvement in overall quality? What we're dealing with here is a very complex product with thousands of component parts and dozens of dimensions to each of those parts. And

necessarily we're focusing on a handful of these.

We are cognizant of the fact that the focus on these little elements takes resources, both financial and monetary resources. And it might be taking resources away from something else. So the aggregate will be a combination of improvement here and maybe degradation somewhere else. And does the benefit outweigh the cost?

Now we probably don't know anything about this, but just raising some of these issues, I think, is important.

My comment is virtually all of the examples that are given as a measure involve some condition, heart attack, followed by some follow on treatment which almost inevitably includes prescription drugs, which of course aren't covered by Medicare. There must be some examples in which the whole kit and caboodle is part of the Medicare package that we could use as examples, rather than good quality consists of after this prescribe something which isn't covered.

MR. HACKBARTH: That may be a comment on medicine.

MR. MULLER: I found this discussion very helpful. Having for years tried to focus on what patients want and then trying to compare that to what professional opinion

would want of the system, and seen the kind of disconnect between the two, the people who do the quality studies and write for the IOM, et cetera, have an overview of what the patient should want, which is very different from what the patient in fact asks for and requires.

One of the challenges one has, building on Bob's comment, is should we be trying to push the patient, inform the patient to be more understanding of what they should want? Or should we try to be more satisfying of the preference that, in fact, they do evince?

I've just noticed over the years and I think in some ways there's an increasing gap between what patients express as to what they want, short waiting list, choice of specialists, et cetera, versus the kind of measures that Bob has referenced as being more what professionals would urge them to do.

Now it's obvious that using agents as a middle ground here is helpful, whether one has the kind of consumer reports or plans as agents on behalf of beneficiaries is something that people have been moving toward for years, given the overall complexity of the medical system and how hard it is for anybody to understand, once they're inside of

it, they should want.

I think consistent with Bob's point, and that's really what triggered this comment, is that a lot of professional opinion, especially professional literature and the kind of call for action -- especially the IOM report -- is different than what patients express, not just here but in other countries as well, as to what they want out of the health system.

So to the extent to which we are pushing more for what the professional literature indicates they should want, that's different than what they vote for when they take action.

MR. HACKBARTH: We need to bring this to a conclusion. Karen and Mary, I hope the input will help and we'll hear more about this next meeting probably.

Our next topic is what's next for Medicare+Choice. Scott?

DR. HARRISON: Good morning. Today I'll give you a quick update on recent Medicare+Choice plan withdrawals and the resulting availability of plans. Then I will present a brief outline of a paper that will discuss some options for the future direction of Medicare+Choice payment

policy.

I would like the Commission to discuss the outline and to provide guidance on which options should be included, and maybe even include some additional options.

The pie chart here illustrates how plan withdrawals at the end of the year will affect enrollees next year. Currently, there are 180 Medicare+Choice contracts that enroll about 5.5 million beneficiaries, which is about 14 percent of all Medicare beneficiaries. At the end of the year 22 contracts will terminate and another 36 will reduce their service areas. All told, about 500,000 beneficiaries or about 9 percent of the current enrollees will lose their current plans. Most of those enrollees will have another Medicare+Choice plan available in their areas, but about 40,000 enrollees will not have another plan and will have to turn to the traditional Medicare program, and another 50,000 would have a private fee-for-service plan as their only Medicare+Choice option.

Speaking of the private fee-for-service option, there have been several recent developments in that arena. Sterling, the one current private fee-for-service plan, has over 20,000 enrollees across their 25 service state area

now. However, it has withdrawn from all of Mississippi and from some areas of Texas, which together account for about 13 percent of its current enrollment.

Of particular note, is that Sterling is withdrawing from areas where 20 percent of its enrollment in non-floor counties reside. So in the places where they're in non-floor counties, they're going to be pulling out where a lot of their enrollees are.

A second private fee-for-service plan will enter the program in January. Humana will offer the plan in DuPage County, Illinois, which is an urban floor county that borders Cook County. This year DuPage County is part of Humana's Medicare+Choice Chicago area plan.

From what I understand, this plan will be offered as one of five demos designed to keep plans from leaving. The demos will all incorporate some form of risk sharing between the plans and CMS. The rest of the details are sketchy at this point, but we'll find more.

This table shows the resulting changes in the plan availability for Medicare beneficiaries. Generally speaking, plan availability will drop by a couple of percentage points. For example, in 2002 about 61 percent of

Medicare beneficiaries will live in counties with a Medicare+Choice plan compared with 63 percent this year. Not on the table, I also looked at zero premium plans and they will decline from 39 percent of the beneficiaries having those available down to 30 percent next year.

That's it for the update portion. If there are no questions, I'll push on.

MR. HACKBARTH: Scott, could I just ask a question about the Humana plan? Did I understand you correctly to say that this was being done in conjunction with CMS and it was part of an effort on CMS's part to keep plans involved in the program and they were going to do some risk sharing with the private fee-for-service plan while providing --

DR. HARRISON: That's correct. I believe the plans are one PPO, one private fee-for-service, and three HMO plans.

MS. NEWPORT: We have one, a demo in Pueblo County, Colorado.

MR. HACKBARTH: All right, so the attempt to do risk sharing is not just with private fee-for-service but with various models, including regular HMOs?

MS. NEWPORT: One of the criteria for even doing

this was, it was to test alternate payment methods, but you had to be the last plan standing in order to do it. It was a combined effort to keep plans in, but also test under the demonstration authority alternative payment methodologies.

MS. BURKE: Glenn, can I ask Scott or Janet, what are the nature of the demonstration risk-sharing arrangements?

DR. HARRISON: Janet probably knows more than I do, but they seem to be sort of risk corridors and sharing--

MS. NEWPORT: Ours was a risk corridor and we presented the proposed methodology and it was accepted. Don't know what other arrangements are except this one now is a private fee-for-service arrangement. But everything was on the table and was judged and evaluated in the context of what their demonstration authority limitations were. So they had to do a new payment, they couldn't just throw more money onto the table under the formula and have it be a legitimate demonstration of something.

MS. BURKE: Is there something other than simply the risk sharing that is being studied?

MS. NEWPORT: Yes, that's my understanding but again, my caveat would be is I didn't see anyone else's

proposal but ours.

MS. BURKE: Murray, it would be interesting over time if they're, in fact, going to put in place this for a year, for us to understand more clearly what are they demonstrating. Whether it's just a question now of what the rates look like and what the corridors look like, or whether there are other issues in the willingness of plans to stay in other than simply rates. Is it just about the rate? Or is it about --

DR. ROWE: My view of it is that there was recognition that the program was underfunded, that the rates were too low, but that there wasn't any way for CMS to increase the rates. So they designed some demonstrations that might have better rates. But the fact is we don't need demonstrations to see whether this program can work. It can work if it's well funded. Janet, what do you think?

MS. NEWPORT: I think that Jack is right. I think that we tried to avail ourselves of the opportunity in order to stay in a couple of markets. We actually applied for, I think it was six different areas, and this was the only one that met the bounds of their demonstration authority. Frankly, I'm not sure that what we're doing now would work

broadly, but only selectively.

I think it reflects a genuine effort on CMS's part to try to do some administrative fixes and be creative around their authority to do some more innovation around ultimately some of the questions Scott asks in his outline, which is what should we do about this?

There's good ideas out there that may not deserve to be explored but they may deserve to be explored.

MR. HACKBARTH: Could I suggest that we hold off on our questions and comments. It's sort of broadening now. Let's get Scott's presentation before us and then we can do our normal round. Scott?

DR. HARRISON: In light of the fact that we keep hearing from Congress that they want help from us in thinking about how to stabilize the Medicare+Choice program, staff is proposing that we focus on options for future direction of Medicare+Choice payment policy and to actually have a discussion of the different options for Congress to see.

With that in mind, we want to start with our view of why we would want to have private plans in Medicare, or what I think our view is why we would want to have plans in

the Medicare program.

The number one choice, private plans can offer beneficiaries a choice of delivery systems. All things being equal, more choice is better than less choice. Some beneficiaries may prefer the delivery system and benefit structures of a private plan over those of traditional Medicare fee-for-service program. As example, beneficiaries may value nurse advice lines, low copay structures, or an emphasis on preventive care that is not found in the traditional program.

Quality. Some private plans could possibly provide higher quality care to some beneficiaries than they might receive if they are in the traditional fee-for-service program. Current managed care techniques that might improve quality include care coordination and disease management programs.

Flexibility. Private plans can often be more flexible to experiment with options that might include efficiency that government programs like Medicare would not really have the freedom to pursue. For example, it is politically difficult for government programs to exclude any licensed providers that would accept its terms of

participation, and some techniques might require limiting participation to a small group. We've seen how hard it is to get centers of excellence, et cetera, approved.

Extra benefits. The Medicare+Choice program and the risk program before it have clearly been successful in providing extra benefits to some enrollees at no monetary costs to those enrolled. Of course, I should note that in the absence of an adequate risk adjustment system, it's unclear whether the Medicare program has borne a cost for those extra benefits.

Competition. If there were enough private plans participating in Medicare, competition among plans and with the traditional program for enrollment could create incentives for plans to encourage their providers to learn new more efficient techniques for delivering health care services. If providers then apply these techniques when treating traditional Medicare patients as well the efficiency of the traditional program could also increase. That's sort of the spillover effect.

Now I'd like to move on to lessons that you can draw from the experience of the Medicare+Choice program. Health care markets are local. The variation in spending

under the Medicare fee-for-service program is substantial. And the success of the Medicare+Choice program in attracting plans and enrollees very substantially. Private plans can't compete with the traditional program, or at least with the Medicare/Medigap combination, in some areas of the country. But in other areas of the country they can only compete if they were heavily subsidized.

Beneficiaries will make tradeoffs, choosing to give up some choice of provider for extra benefits. Medicare+Choice plans have been very successful in attracting members. Over all areas where Medicare+Choice coordinated plans are offered, about a quarter of Medicare beneficiaries have chosen to enroll. The Medicare+Choice penetration rate is much higher in some areas where plans can enroll 40 to 50 percent of Medicare beneficiaries. The bottom line here is that many Medicare beneficiaries really want these plans.

Private plans should be expected to come and go, however, as they do in commercial, FEHB, Medicaid, and CalPERS markets. Private markets are dynamic and when private plans are used to provide Medicare benefits, we should expect the program not to be static. Beneficiaries

are not likely to see the same stability that they expect from the traditional Medicare program.

I'd like to present three general options for the direction of the Medicare+Choice payment policy. One, to establish financial neutrality between the Medicare+Choice plans and the traditional Medicare program. Two, to pay plans more than fee-for-service equivalents in order to attract plans to more areas of the country. And three, to use competitive bidding to find the right rate to pay plans.

The first option reflects recent MedPAC recommendations. Once an adequate risk adjustment system is implemented -- and of course, that still may take a couple of years -- rates should be set at 100 percent of the Medicare fee-for-service per capita spending in the payment area. A specific goal of this option is to encourage plans to offer beneficiaries a choice of delivery systems and benefit packages, so long as there is no additional cost to the Medicare program. Also, by leveling the financial playing fields at the local level between plans and traditional Medicare, the local markets would be allowed to determine what types of plans are successful in each area.

Although this option seems straightforward, there

still would be some challenges to overcome. The successful implementation of an appropriate risk adjustment system has been difficult. At this point, CMS has suspended the collection of outpatient and encounter data that they had intended to use in the risk adjustment system because the plans objected it was too costly to collect. CMS is exploring its options, but has yet to announce a resolution.

The other challenge is to get the political system to accept that some people in the country will have access to extra benefits and others will not. This has not been easy to do, as evidenced by the legislative increases in the floor rates.

Option two is to pay more than the fee-for-service equivalent to attract more plans, especially are to areas that don't currently have any choices. Examples of recent uses of this option have included the floor rates, blended rates, and bonus payments to plans who enter areas where there are no existing plans.

The goals of this option include the expansion of plan choice to more areas and the encouragement for plans to offer higher quality care and/or expanded benefits. One other goal that might be served by this option is to keep

plans in the program so that they might be available if the Medicare program were to be reformed.

This option would raise many basic questions. How do we decide how many plans we want and in what areas? How do we decide how much subsidy to provide? How do we target subsidies to get the plan distribution we want? And what tradeoffs do we make between spending more money and having fewer plans?

Option three is to develop a competitive bidding process. You could argue that we have a competitive bidding process now, but it is not now used for setting payment rates to plans. There are many possible formulations for a bidding process, but today I'll just lay out some of the basic goals and issues.

One basic goal is to increase beneficiaries' choice of plans for the same or lower cost for the Medicare program. Another type of goal would be for the competitive market to use price sensitivity to drive value and reduce the cost of health care.

In setting up a competitive bidding process, a whole host of decisions would have to be made. Would the benefit packages be standardized? If so, then the

competition would be focused on price, otherwise the competition would be on price and benefits.

How do we deal with the geographic variation across the country? What would the payment areas look like? Would there be national components to the rates? How would we manage the process so that budget constraints are maintained? One of the big questions is what would CMS's role be and how would the traditional Medicare program be included in the process? Would it be a bidder, as well? Is it okay if the traditional program is the only choice in some areas? If not, do we need to recruit national plans? And last, but not least, in making such a change, how would be begin to demonstrate such a program before full implementation, given that we've had trouble with launching demos before?

Thank you.

MS. NEWPORT: Scott, I know you're aware of this -- because we've been around the block on this one before, but there's been comment made to us that instead of about a million folks being affected by exits from the M+C program as has been in the last few years, it's about half of what it was. So that there is a perception that it's slowing.

I think that that's the wrong impression. I think that there's two things that need to be involved in the analysis.

The other thing that Scott probably hasn't been able to measure is the change in the benefit packages, which may have an impact on shrinking the enrollment even further next year. Because the magnitude of change that I've seen in some of our markets is very significant. Increased monthly premiums, shrinking the pharmacy benefit. And I think that I have pushed our folks around a little bit internally to say what do you think that indirect number will be? And I think there's too many variables in terms of who else is left in what market and what the package looks like. And I think that the growth is significantly declining.

The other problem we have is that the expectation for Medicare reform has been postponed. I never thought it would happen this year anyway, but I think that there had been a promise or a hope or whatever somewhat optimistic attitude you might want to take on this, is that plans would have a line of sight to what reform looked like vis-a-vis what their potential participation payment, all of the

things that come with that. And now, and we know why, it unfortunately has gone away in terms of a delay in what reform will look like and how we measure that and how much money will be on the table for a drug benefit.

So what we look at now is what I'm calling a bridge to reform. What is going to be there as a placeholder to keep, at worst, a steady state. But that it is very problematical for the plans, in terms of having the vast amount of uncertainty over this.

For the record, PacifiCare exited between 65,000 and 70,000 enrollees, depending on what database you use and the timing of the database with HCFA's data versus ours, and that's a timing issue. But I'm very concerned about what the net effect indirectly on enrollees is.

I've thought about every kind of payment option there is out there, in terms of risk, but I think the competitive bidding option is still clearly on the agenda of Congress, in terms of what they would like to do. Some model off of that. I hear a constant refrain, they're still there. And I think that the focus of the various options in the paper, we need to acknowledge that maybe there's some reordering in your outline, Scott, that I would suggest.

It's just that I think we have to look at that. And then obviously look at other options, in terms of what effect it's going to have.

There is this sort of naivete, I think, around investors in our programs confidence that the government is a useful partner. I think that makes it really difficult from some standpoints. In the balance, we have to strike in terms of our participation in the market, and even in the commercial markets, because they're interwoven.

So anyway, Scott, I think you've outlined the issues. I think, at this point, once we see a draft, it will be helpful. But I would want to have a placeholder there about the effect of benefit changes on participation by enrollees. And again, I know you haven't had a chance to do that yet.

We're not even sure exactly what that is. We have surmises. But I think what we do as a Commission, in terms of consistency with our earlier reports, which talks about payment off 100 percent of fee-for-service, and creating a balance between that and what competitive bidding does.

Getting incentives out there so there's new entry and expansion in the program for participants or contractors

will have to be reliant upon, I think, our satisfaction if you will that there won't be a lot of huge change every year. We're feeling that every time we turn around there's another set of changes and another set of costs. Some of these are related to other things that are happening, too, including HIPAA.

So I think part of it would say is just fixing payment -- just some basic changes to the payment, but don't change it so drastically that it creates a continued disincentive to new entry. I think the key is how we incentivize new entry and expansion, instead of enrollment decline. But other people will weigh in on the debate as well, I'm sure.

DR. ROWE: Just a couple comments. I think this is very well done. For the record, Aetna was in 49 counties, withdrew from 23 of them, stayed in 26 of them. The criterion I applied was if the average medical cost ratio projected for next year in the county was over 100 percent, we should withdraw, not counting administrative costs. That was the criterion that was used. The average projected 2002 medical cost ratio in those 23 counties was well over 100 percent. So this is not, as some people

think, well it's at 78 percent but we really want it to be 74 so we'll withdraw.

I had a couple of comments. With respect to Janet's comment about the benefits buy down, I think there's another factor going on here. I think that while a smaller proportion of plans withdrew or members were withdrawn than everyone expected, that that is misleading because there are a very substantial number of plans poised on the cliff. And I think that as you analyze the data, Scott, if they become available to you, what you will find is that many of the plans, if not all the plans, have increased the supplemental premium to the maximum permitted number. That's what they have done this time in order to try to stay in the county.

So it's not really you're in or you're out. It's you're in with what benefits at what supplemental premium or you're out. And what everyone has done is increase the supplemental premium to the max in order to stay in because people want to stay in the program and serve the beneficiaries. And the next time around, if financial performance continues to deteriorate and there is no place to go, down on the benefits or up on the supplemental premium, I think we will see a very substantial number of

people bailing.

So I think that for that component of this chapter, the benefits as well as the supplemental premium issue, should be included. That would be my recommendation.

With respect to the various options, I think that it is true that many people and many elected officials feel that many people love the program and want to stay in the program. But the question is really do they love the old program with free eyeglasses and pharmaceutical benefits? Or do they love the program that they could get now? I think that that distinction is not sometimes made in calls that I get from elected officials, we have that conversation about well, even if I were to stay in I couldn't offer what they used to have, which is what they remember.

There is a very interesting principle that Bob Reischauer articulated, I think, most clearly for me a couple of years ago, before I was in this side of the health care enterprise. That was that the idea was to provide choice for the Medicare beneficiary at no additional cost to the program. And I ascribe to that and I think that that makes sense. That guided me in my thinking.

You now have an option here, which people are

increasingly talking about, about paying more in some way in order to try to make this available and what might the rationale be. One rationale that I have heard, that might be included in whatever you write and you might decide to discard it or support it, is that in fact, in a local market, because of the Medicare market share and the pricing power that they have with physicians and hospitals that, in fact, an individual plan cannot compete at the same payment because it doesn't have the muscularity that Medicare has with respect to its pricing. So that in fact, depending on the market shares, et cetera, there's just no way to get there.

So that is just an idea that some people have espoused and then might go into the mix of things to be considered.

The last thing I would say is really an echo, I think, of what Janet said. On page four, number C of your outline, you do have a section of competitive bidding, which I thought was very interesting and very nicely done. I didn't see that slide. If my having missed that slide does not suggest my inattention, but the fact that it may have fallen off the current version of the outline of the

chapter, I would suggest you put it back on and have some discussion about it. Because I don't know if we're going there, people closer to this might know more about whether we're going there. But it's certainly interesting and if there is discussion in Congress about it, then it might be helpful for us to have something to talk about next time. Maybe others here know whether, in fact, it has any legs at all.

Thank you.

MR. HACKBARTH: Does anyone want to respond to that?

MS. RAPHAEL: I just had a question on competitive bidding. I was wondering if you could explain a little more the rationale for people paying a premium for staying in the traditional fee-for-service system?

DR. HARRISON: In the outline I had given you I had presented one potential model for a competitive bidding system. The major motivation behind that particular model was to try to keep things equal across the country, so that all beneficiaries would have access to the same benefit package at the same price.

Because of the variation in fee-for-service what

you would have to do is, in some areas of the country, people couldn't get that package by going through the traditional Medicare program. Because let's say in New York, the traditional Medicare package may cost more than it would cost a managed care plan to provide that same benefit package. So the idea was that you would make the entitlement to the actual benefit package, not to getting traditional Medicare. So in some areas of the country then, perhaps in New York, you'd end up having to pay a premium to get that benefit package if it was delivered through the traditional Medicare program.

MS. RAPHAEL: So would the flip be true?

DR. HARRISON: Yes. So in places where the fee-for-service program were more efficient, you would stay in the traditional Medicare program and you would have to pay if you wanted to go into a managed care product.

DR. REISCHAUER: Just to add on to Carol's question, or the answer to it. When you set up a competitive system you have to have some kind of reference price that you are competing around. Some of these models have it the lowest bidder in a geographic area. President Clinton's policy was ever Medicare fee-for-service costs in

the area. The Bipartisan Commission's variant was sort of the average of the bids in an area. And so you can set this thing up anyway you want.

I think most of the political interest, in the short run at least, is in options that would hold people in the fee-for-service system harmless. So they would say to people in the fee-for-service system, if you want to stay in that you don't have to pay anymore than what you're paying now. You choose a more efficient plan that has a cheaper premium and you'll get a rebate or some extra benefits. You choose a less efficient plan, you'll have to pay more on top of that.

An observation on the comments that Jack and Janet had, which I would hope that when we talked about the supplemental premiums we would talk about them in the context of the counterfactual. What's the alternative? And the alternative is Medicare fee-for-service plus Medigap. And what's happening to those payments as well? The salvation of PacifiCare is rapid rise in Medigap premiums, one would hope, and you, too.

Some observations on your material, Scott. One is sort of on the why we have private plans in Medicare.

Choice and quality I'll buy. Flexibility, competition and additional benefits at no extra cost, I think, really collapse into two things. One is innovation, which can come out of competition and other things. That's why we're interested in it. The second is saving money, either beneficiaries saving money or the system at large saving money. Competition for competition's sake is sort of like who cares? Or flexibility.

The other observation is I thought you made too much out of changes the norm and private markets and went a little overboard there. In general, you're right and we don't care about entry and exit for gas stations, but consumers do care a lot about continuity when it comes to lots of other services and products they buy. And insurance is a key one.

If your life insurance company was changing, your car insurance company every year, there would be problems. And so I think you should talk about how in some services continuity is an important component of the quality of the product you're buying, or dimension of the product you're buying.

DR. HARRISON: Right. I thought one of the

lessons really should be that if we're going to have private plans, we need to make the transitions easier for the seniors, the beneficiaries.

DR. REISCHAUER: Right. And it's an argument for having relatively high hurdles for who can enter the market, so they aren't sort of fly-by-night people who are here today, gone tomorrow, and they're making commitments and have the ability to stay with it for five years.

DR. BRAUN: I just wanted to remark that I think particularly in the part of the outline where you talk about what lessons can we draw from the Medicare+Choice experience, I think we ought to add one more in, and that's the need to protect the traditional fee-for-service because of the natural instability of the private market. We need to be very sure that traditional fee-for-service is there when other things aren't.

MR. FEEZOR: I wanted to, I think, concur with Janet and Jack's observation that while this year may be a little bit of a slowdown that we've seen, that if California is any harbinger of things to come, it will certainly increase and continue. The pressure will be on further erosions.

Second, I guess I'd like to reinforce Bob's comment, that I think that one of the objectives from a public policy standpoint in the M+C plan or going with choice was, in fact, trying to save money or make some tough decisions that perhaps we, as a society, aren't willing to touch. And yet, from the individual standpoint, clearly the preference -- and again I said a little earlier -- I almost want to do a takeoff on the Clinton campaign. It's the security, stupid. It really is the sense of better value and the certainty that our seniors expect and want to expect, and compared to an absence of that, either in terms of comprehensive coverage or perceived value, that really sets it up.

When CalPERS was struggling, I have a PPO plan that is, I guess, the equivalent of the regular Medicare fee-for-service. It's pricing is getting so disproportionate that it is no longer the choice. It's the only choice that all counties in California that I can provide. It's the only one that's provided nationwide, as well. And it is so extraordinarily expensive that the value that my enrollees perceive in the HMOs compared to my PPO is just so out of proportion, that they are not happy when

there is only that single choice left.

But again, it is not choice that's driving it. It is, in fact, the value and the lack of comprehensive coverage.

Janet's right on target. If you look a little more carefully behind the benefit-to-premium ratios for the remaining market, I think as you will see -- and again on Bob's observation -- the pricing of the M+C plans which were largely, I think, underpriced to begin with, as they begin to rise up to meet other alternatives it will be interesting to see if that sort of loyalty remains.

I think there is because of some additional comfort, security and value that our enrollees feel in many of these plans. But that certainly will be tested.

One other thing, this gets back to the sense of security or certainty in those plans, I think one of the things that's really making it very hard on the Aetna's and the PacifiCare's of the world to stay in is the dramatic fluctuation of the underlying inputs. It's countercyclical to our economy's ability to afford it. And that also translates to our individual enrollee's ability to afford it.

I don't know what attention or energy we can bring to that, but I can tell you the amount of repricing that we have going on from the provider side in California -- perhaps we enjoyed depressing those rates -- maybe now what I can call the variable interest on our mortgage has come due. But having to make it up all in one or two years is absolutely cataclysmic to the market. And I think again, not recognizing the underlying tremendous variations that plans have to encounter to stay in the market to provide that sense of security and permanence that our enrollees demand is something that needs attention.

One thing, Scott -- and by the way, I thought it was an excellent outline of a difficult area -- we talk about rural floor counties versus richer or higher cost counties. Maybe I'm a little too blunt-spoken for Washington, and probably for Sacramento to some degree, but it really is most of the erosions that we see, not just in our Medicare market but in our standard choice market -- under-65 -- is really a non-competitive market. Where in fact the negotiators, whether it's my own PPO or whether it's the Cigna's of the world, simply cannot get the margins they need between -- and when you have Medicare's purchasing

power, as I think Jack talked about, is what you have to compete with, that is very unrealistic. But it is largely in what I call, and I think you need to make some reference to it -- it's not just in low cost counties. It may be that a low cost county where providers are willing to, in fact, negotiate or engage in care management, that they will still succeed. But in counties, in fact, where the provider is disinclined either to engage in terms of more realistic pricing or in terms of significant involvement in care management is probably where most of the problem is.

And then finally, down the issue that I do think we need to warn our friends on the Hill about, and I caution us, we talk about the fact -- I think Scott your term, we need to make sure our seniors are able to handle the transition if we, in fact, are stretching a market that has greater entrance and exits. Let me just tell you, having made one in eight or one in nine of my enrollees have to choose and move to a new plan this year in the attempt to save about $135 million or $140 million. My board thought that was a great idea in April. And now in August and September when those complaints, even though we had predicted exactly how many new people would be displaced by

this and they said yes, it's good value, it's a good thing to save $135 million or $150 million.

But my board, who in many respects is a representative or a legislative body, had a very different opinion in terms of what value was important. So I do think that we need to warn that if we are talking about a marketplace or relying on a marketplace where there are greater entrance and exits, again -- particularly for our seniors -- the sense of security -- and if you look at the number of -- each year my 30,000 people until this year I'm putting 150,000 making the change.

Of the 30,000, the smallest percentage who make changes are the seniors. They like to make that choice and get comfortable with that. And so to expect that they will migrate mightily for another $2 here or there, I said they are able to seek out good value. But I think for my senior population there is perhaps a greater threshold that they expect before they will move.

DR. NEWHOUSE: I have two comments. The first is a deja vu all over again comment. For this program to work reasonably well for all the parties who have a stake in it, there is going to have to be tolerably good risk adjustment.

Now to the degree -- and Scott recognizes that.

The point I'd like to go on further here is to the degree that this process is inevitably playing out over a longer time period, encounter data collection is on hold, it seems to me that the logical consequence of that is to go to risk sharing or partial capitation and, in fact, have an increased weight on that.

I would actually be interested, not now, in finding out what CMS plans are to evaluate these demos, what questions they're asking and what they hope to learn from that. But leave that aside. That was in here but it wasn't really brought, I thought, sufficiently emphasized in the talk.

The second comment is that, from my point of view, the worst of these options is a subsidy option by far. My concern with it is that if one wants to say that plans aren't going into areas where they don't have much bargaining power, which I think is in fact the case with providers, and there's effectively local monopolies with either or both of hospitals and certain physician specialities, that even with subsidies you're still not going to have any bargaining power. And so the degree you

put in subsidies, the subsidies will pass along through to the local providers and the plans will know that. So they still won't go there, so you really haven't accomplished anything in my view, except potentially to up rates to local providers through the plan.

MR. SMITH: Very briefly, Glenn. Joe's last point was the point I wanted to make. I guess the thing that occurred to me, listening to Janet, Jack and Allen -- and Scott you get at this some, but after listening to our colleagues, it seems to me maybe we want to try to emphasize in this section a little bit more of the sense around this table of the illusion of choice. That if what we're having is a regression to the mean and that, with some combination of premium increases, exits and benefit reductions, all we're going to have is a choice about who you pay fee-for-service rates for. But we ought to say that.

The Commission has certainly come to that, or at least expressed that view in several ways. But it's very important, it seems to me, as a predicate to this discussion again that if we think what's happening in this marketplace is what choice was a proxy for, which was additional benefits, are being eroded then we ought to be clear about

that. And if the new data allows us to say that more clearly or describe that trend, we should.

I guess the other thing that I'm struck by is the importance of this conversation for the end of the agenda tomorrow, which is the benefit package discussion. This is ultimately about the benefit package. And even though a lot of the folks who call you, Jack, say what they're interested in is choice, that's not really why senator whoever is calling you. They're interested in protecting a more modern, more aggressive benefit package for constituents who are mad that Aetna is pulling out.

Again, we ought to be clear about that, it seems to me, in this chapter and try to get this discussion focused on the real issue which is the benefit package and our inability it seems in many marketplaces in the country to improve the benefit package with the choice mechanism. And say that more explicitly than I think you have before.

DR. ROWE: If I may add a point here, one way to say what we're all saying, maybe the unit of this analysis should not be the health plan but should be the beneficiary. One way to talk about this is to say this is about the beneficiary. And what, in fact, is it going to cost the

beneficiary, traditional Medicare plus Medigap versus what's really out there in the market, supplemental, what is the benefit package, et cetera, et cetera. Rather than the economic analysis of the pricing power of Medicare versus that of the health plan.

That's important, too, and I support that. But at least once slice of this should be trying to look at it through the lens of the beneficiary and what the real choice in the current market is.

MR. HACKBARTH: The point that I keep coming back to, the question that I keep coming back to, is it good policy under some circumstances for the federal government to pay more for a beneficiary that chooses a private health plan option? I've bored people to death saying over and over again that my world view is that we ought to offer a financially neutral choice between the traditional fee-for-service program and private options. I'm trying to open up my mind and think new thoughts here.

There are various ways that we might arrive at that destination, various mechanisms we might use to pay more for a private option than Medicare. I agree with Joe's comment about a subsidy probably being the worst of those.

But let's take competitive bidding as an alternative framework that may well arrive at the same result of a higher payment for a private option.

The question I keep coming back to is how is that ultimately any different -- let me just finish Joe, and then you can set me straight.

How is that any different than what we have criticized under the private fee-for-service option, where we see the floors as creating an opportunity for a private plan to come in and basically do nothing, add no value, use the Medicare payment systems even for providers and just benefit by the arbitrary separation between what they're paid and what the fee-for-service program pays? I just don't see the public policy benefit in that separation.

Okay Joe, what did I say wrong?

DR. NEWHOUSE: I was going to agree with you, but I guess I still have a closed mind on neutrality. I was going to emphasize the flip side, that in the high rate areas we're now paying less and we shouldn't be surprised if we see exits when we do that. This goes back to the all health care markets are local point and the non-neutrality point.

I think both sides of this deserve emphasis.

MR. HACKBARTH: Right. Just to pound on that same point, if we have an artificial cap on what we pay private plans, potentially what we're doing is having plans exit and losing opportunities for Medicare beneficiaries to get more benefits, for there to be more competition simply because of an arbitrary public policy limit.

And on the other side, if we're paying more for the private option, we'd have these opportunities for gaming the system. I just can't find a way out of that box and I keep coming back to neutrality is really the only logical acceptable stance for Medicare on this.

MS. RAPHAEL: These sort of go back around to why you said you want a private plan. It increases choice, quality, flexibility, competition. Now we're questioning choice as to whether or not that's valid. Let's assume it is, then quality, and then innovation.

I think from my point of view if you're going to put in the subsidy, how clear are we on the benefits side of this equation? Certainly in what we've seen here, we don't have much empirical evidence to me. It's a lot of in the future, these private plans might innovate, it might

spillover in fact to the other side and have some beneficial effect.

I don't know what you have on the quality side that might be meaningful.

MR. HACKBARTH: In fairness, I guess it boils down to a question of how much are you willing to pay for these benefits that Scott has enumerated? I'm wondering whether we ought to be paying that price just to say you have a private option.

DR. REISCHAUER: I think it's very hard to make a case that just to provide choice, when choice offers nothing else -- it doesn't offer quality, it doesn't offer innovation, it doesn't offer any kind of spillover effect -- is worth paying a penny for. But what your formulation, which is neutrality, says other things being equal, if you don't have to pay anything more for it but we have an opportunity to provide choice, then provide choice.

DR. ROWE: I think the issue is what is it a choice of? Because we can write articles about how managed care offers disease management and utilization management and blah, blah, blah. But the fact is, from the consumer's point of view, it's whether it covers prescription drugs or

not.

DR. REISCHAUER: No, but there's something more to it than that. It is that you have a different cost sharing structure in almost all of these plans than traditional Medicare alone. And that is important for a lot of people.

DR. ROWE: I think that's right.

DR. REISCHAUER: So forget about the drugs, forget about the vision care, all that stuff. Just laying out a plan that has no hospital deductible, small hospital copayments, is worth something.

DR. ROWE: That's one analysis from the bene's point of view.

MR. SMITH: It's certainly part of what Janet was saying. What's eroding are those kinds of benefits, whether it's measured in terms of premium increases or copay increases. That does appear to be what's eroding, even when there's not an exit.

DR. NEWHOUSE: I agree with the comments that have been made about the beneficiaries' point of view, but I think there's another reason for this plan, which goes back to how we spend most of our time in this commission, which is worrying about potential or actual distortions that are

introduced by the administered pricing schemes in traditional Medicare.

We worried about is the geographic adjustment in the wage index right. We worried about is there going to be substitution of care from home health agencies to SNFs or vice versa because we have two different payment systems or from the outpatient department to ambulatory surgery centers. And we spend hours and says on trying to fine tune what amounts to a national system that inevitably is going to have some misses at the local level, potentially significant misses.

By basically trying to free up the plan below the plan payment to contract with providers in the local community it seems to me we escape a lot of the potential distortions that the administered price system that traditional Medicare inevitably has to use, given its essentially dictum that every provider is going to be in it, has to use. And that's another reason for wanting this that I think hasn't really been brought up here.

MR. HACKBARTH: Scott, are you okay?

Okay, the next topic is consumer coalitions in Medicare, a report that's due in December 2001. Susanne and

Scott?

MS. SEAGRAVE: I'm here today to talk about MedPAC's mandated report on consumer coalitions in Medicare. Just to give you a framework for the progression of this report, we were going to present our findings on this in September and allow the Commission the chance to discuss the findings before we drafted the letter report. Because of the compressed time frame, we went ahead and drafted the letter that is included in your meeting materials. That letter, with the attached Mathematica summary of the expert panel meeting that we had this summer, are intended to satisfy the mandate. We hope to be able to finish those up at this meeting. We would like to get the Commission's feedback on both of those things.

This study is mandated by the Benefits Improvement and Protection Act of 2000. BIPA required MedPAC to make a recommendation concerning the potential of consumer coalitions for Medicare and the merit of conducting demonstrations to test their feasibility. This mandated report is due to the Congress by December 21st of this year.

I'd like to begin by outlining the concept of consumer coalitions in Medicare. According to the

proponents of the idea, coalitions provide localized information on fee-for-service Medicare and other Medicare options, including Medicare+Choice, Medigap, possibly long-term care insurance, and prescription drug coverage.

Proponents also envision coalitions acting as purchasing agents, negotiating with insurance companies for better benefits or lower premiums on behalf of their beneficiary members.

The proponents envision a structure in which individual Medicare beneficiaries would have the option of joining coalitions which would be run by community-based non-profit organizations with oversight from a board composed largely of Medicare beneficiaries. Beneficiary participation in these coalitions would be strictly voluntary. Meaning, for example, that an individual beneficiary member could decide, after the coalition completed its negotiations, whether or not to sign up with the plans or insurers that the coalition completed its negotiations with.

The coalitions would also receive direct federal funding.

To study the question posed by Congress, MedPAC

staff analyzed the findings of an expert panel meeting which Mathematica convened for us in July under contract with us, to discuss the potential for consumer coalitions in Medicare. We also interviewed the advocates of the consumer coalitions idea, spoke with CMS representatives, and did a site visit to the D.C. SHIP.

The D.C. SHIP is representative of many of the SHIPs nationwide, has some similarities, some differences, but it conducts telephone and face-to-face sessions and other types of things that the SHIP network nationwide provides.

From this analysis, MedPAC finds that coalitions would likely not add value beyond what the SHIPs could do with additional funding, and could add another layer of confusion to an already complex system for delivering beneficiary information. Non-profit organizations can already participate within the SHIP system to disseminate beneficiary information, but if they were to receive separate direct federal funding would introduce another competitor for limited available funding.

We find that coalitions would likely not have enough leverage to negotiate effectively with insurers in

local markets because they would bring relatively small membership populations to the negotiating table. And the voluntary nature of the member participation would mean that the membership population the coalition did bring to the table would be highly uncertain, since beneficiaries could decide not to sign up with the insurer even after the negotiations were completed.

Finally, the coalitions could potentially face adverse selection problems. In addition, the non-profit organizations that would run the coalitions likely lack the necessary expertise to negotiate effectively with insurers.

In view of the potential for coalitions to cause confusion and their limited potential for success, we recommend that the Secretary not conduct demonstrations of Medicare consumer coalitions.

MR. DEBUSK: I agree.

DR. WAKEFIELD: The document that you gave us to read in advance certainly takes the reader, I think, right to that conclusion. There's not much in the way of pros that are listed, in terms of supporting an alternative to what you've recommended.

Though I was interested with the footnote on page

two of the document you provided us. It says the panel that Mathematica convened reached a consensus across the groups that were represented at the table. And I was really interested, and we just got that today, who was on that panel. Because I was kind of surprised, it's so rare you see consensus around anything. This would be one such thing. So I was kind of surprised that this was such a slam dunk, taking us to the recommendation.

So for example, you've got the National Council of Aging, we just got this one-page document today, too, which seems to be a dissenting voice, and yet they were on the expert panel.

So I'm wondering, was this really a consensus or was there a different view?

DR. REISCHAUER: Just like the one we had on rural issues.

[Laughter.]

DR. WAKEFIELD: You guys made the mistake of expressing a different view after the fact then, Bob. Sort of a private conversation, for the rest of you. So there's my question.

Maybe we ought to be just a little bit cautious in

terms of what we're submitting. I think the convening of that panel was really important. But if there was some other opinion expressed, maybe we ought to soften that language just a bit.

DR. ROSS: As one who was in the room for that meeting, if you don't like consensus, it wasn't unanimity, but overwhelming majority.

DR. WAKEFIELD: That would be fine.

MR. FEEZOR: Just as a disclaimer, when I was a regulator about 15 or 18 years ago we brought up one of the first SHIPs and then lobbied to get some federal grant money, which became institutionalized. I need to do that, though I haven't talked to those folks in about seven or eight years.

I think it is important, and Susanne, like Pete, I agree pretty much with the conclusions. I think maybe there is two things that bear pointing out.

One is, correct me if I'm wrong, none of the SHIPs do collective negotiation with insurers. They're more fact and disclosure. So we need to make that as one significant difference that I think the people who suggested different consumer coalitions be formed, that SHIPs were never

intended to do and, to my knowledge, do not anywhere in the country.

Second, and I think the SHIP programs do extraordinary work. The one in California does excellent work, as well as the one in my native state of North Carolina. I guess I wonder, though, if it might be appropriate that the Secretary or appropriate entity try to get some measure on the effectiveness of those entities.

I guess my question would be probably not all of them are equally effective and there may be some states that, in fact, do not have benefit of effective or strong SHIPs. And it may be that some consideration may be given to trying to spark or regenerate effective information counseling services in those states where that is not present, as one of the actions that might be taken short of funding new coalitions.

DR. REISCHAUER: From the information you gave us, Susanne, it seems an unambiguously bad idea. So I was wondering how it even got this far?

I was wondering, if I understood this correctly, when we're talking about these organizations as negotiating bodies, you become a member of one of these organizations

and they negotiate with Aetna. And then Aetna offers a plan that is only available to those people who are in the group? Or is the group open so anyone can then subsequently join? And is there then, as you said, a small fee maybe of $10 to join? Which is a hurdle to get what, in the rest of Medicare, is basically open entry.

It just struck me as something that went against the grain of Medicare as a universal entitlement program.

MS. SEAGRAVE: Just to answer a question really quickly, what the proponents are proposing is to actually run demonstrations of different models. So they're not proposing one specific model. So it's not clear exactly would -- it's not clear how they would work with the insurers, whether they'd work with just one insurer, or multiple insurers. They're proposing to test different models, in a sense.

So everything that you mentioned could potentially be in one or another model that they're proposing.

MR. HACKBARTH: All other things being equal, I love the idea of demonstrating new ideas. What holds me back in this case and some others is that the potential topics for demonstration far outnumber the resources

available to do it. So I think we need to be cautious about adding still more to the list.

I want to focus on the purchasing coalition piece because for me there are some disconnects, just based on my own personal experience in dealing with people like Allen Feezor around negotiations. Employers are effective in negotiating with health plans to the extent that they are empowered to make decisions, steer people to particular contractors, take away options. That's what gives them their leverage.

The question that this raised for me is the extent to which these sorts of relatively loose affiliations of people, voluntary associations, will be able to actively, aggressively, direct populations -- enough of a population to a health plan to be able to get anything for it. If you can only steer a few people and they're of unknown risk, you've got an inherently weak negotiating position. If you can steer a lot of people with a reasonable assurance of a variety of risk, or a relatively normal selection of risk, you can drive a pretty hard bargain.

I don't see how you get to that hard bargain situation with these voluntary groups. That's the question

I keep coming back to.

You're shaking your head, that sounds similar to what you heard in the expert panel?

MS. SEAGRAVE: Yes, definitely. In my discussion I said that, first of all, the feeling is that these coalitions memberships would be very small, that they would be highly uncertain, and that they could even potentially have some adverse risk selection problems. So they would have difficulty getting that leverage in the market for those reasons, and possibly for other reasons, as well.

DR. REISCHAUER: But just at this moment in our history, we hear from Jack and Janet that many of these plans are teetering on the edge. There's not a lot of let's say fat or rent to be extracted from them anyway. Why would we want to move forward with a demonstration to see whether a weak body could extract fat from a thin person.

MR. HACKBARTH: That's a nice summary.

MR. SMITH: I, predictably, would express some reservations about assuming that any voluntary group of folks who want to bargain are weak. But it does seem to me it ought to be a voluntary group of folks who want to bargain, not a group of folks created by the Secretary

through a demonstration.

But more importantly, trying to follow Allen's point, the summary documents suggest that while some SHIPs may be doing terrific work, that knowledge of the program is uneven and, on balance, inadequate. It does seem to me that we might want to pick up on that finding and ask ourselves whether or not something the Secretary ought to do -- either best practices work, disseminating lessons from the better SHIPs, perhaps reconsidering possibilities of additional funding that tries to improve beneficiaries' understanding of the program and access and ability to manipulate.

I'm not sure that consumer coalitions are the answer. And if they are, I'm not sure the Secretary should pay for them. But it doesn't seem to me we ought to ignore the evidence that suggests that information is inadequate and think about ways to improve it.

MR. HACKBARTH: Other comments or questions?

MS. NEWPORT: Our experience with the SHIPs, in terms of access and information for beneficiaries, has been very positive. Much to their chagrin I told that to them, and they're not quite sure what to make of that. And it is true, and I think we look to them sometimes as a valuable

partner in getting information out.

But there are various skill sets out there amongst the states, and California is particular good, by the way. I agree with Allen.

I just think that when I look at the notion that they can negotiate better drug prices for beneficiaries, help with that, a little bit of a reach. We're having, with a million members in our program, a continuing challenge in doing that and we actually do very well at it.

But I really do agree with the rest of the Commission, in the need for the right kind of information, well thought out, well delivered, has always been a challenge. And we should support and continue to support that.

I agree with the recommendation. I think we just need to make sure the information is the right scale.

MR. HACKBARTH: I think the question that we're faced with is not whether these are good ideas or bad ideas, or whether maybe they would work in some local circumstances or not. Rather, the question is is the level of promise sufficient that we would recommend that very scarce resources of demonstration dollars be applied to this topic.

I just want to be clear, from my perspective this is not about condemning these ideas, or even saying they can't work. They won't work under some circumstance, but we're rationing a scarce resource here and the recommendation on the table is that in that context, in view of these scarce resources, this isn't a sufficiently high priority that we ought to recommend or require demonstrations.

I think if we can dispose of this today it would be a good thing to do. Are people ready to vote on that?

MR. FURMAN: If the committee is going to make a decision, I'm the author of this report. I would request the opportunity to talk for two to three minutes.

MR. HACKBARTH: Okay.

MR. FURMAN: Thank you. My name is Jim Furman. I'm the President of the National Council on the Aging and the founder of the United Seniors' Health Cooperative, a consumer information coalition founded by Dr. Fleming and Esther Peterson.

The impetus for this study, for this whole effort, was a feasibility study funded by the Retirement Research Foundation with four authors: myself; Dave Kendall from the

Progressive Policy Institute; Jay Greenberg who is the founder of social HMOs and also the CalPERS Quantum Care product; and Dwight McNeil who is an expert in employer purchasing programs.

Involved is an eminent expert panel of people, Stuart Butler, John Rother and a variety of other people, who are also part of the recommendations for this report.

I would at least request -- I'm a bit troubled by the fact that that report -- I'm not aware whether that report has been made available to the members of this committee as well, presenting and I think answering many of these points of views.

I would like to clarify a few points. First of all, we're proposing two separate types of organizations, an information coalition demonstration and purchasing coalition demonstration. Let me speak to the specific concerns that were raised about both of them.

The concern was that the information coalition, there would not be any value added, other than funding the SHIP program. The current reality of SHIP program, for anybody who's involved on the ground level, I'm not aware of any program that reaches more than 2 or 3 percent of the

beneficiaries in their state. In fact, most of the delivery of services is by volunteers who have probably had six or eight hours of training, and therefore are quite limited in their ability to provide substantial information.

The comment was made, for example, in Washington D.C. we visited the SHIP program. In addition to the SHIP program in Washington, D.C., there's the United Seniors' Health Cooperative, there's AARP, there's employers, there are all groups. What we have now is tremendous duplication. We have six or eight groups, all producing your basic one-on-one guide to Medicare and not much more sophistication beyond that.

The specific recommendation was to create a different paradigm and a public/private partnership for the delivery of education and counseling information that would leverage all of the resources of employers, of union, of AARP chapters, of other groups to provide that information and to also reduce what is now tremendous duplication and lack of reach.

In addition, private groups have the ability to say what needs to be said. I, by the way, was a strong proponent of the SHIP program. But if you go to a SHIP

program and said what about American Integrity Insurance, Provider Fidelity Insurance, United American, companies which have terrible reputations, the answer you will get is they are licensed to be sold in the state. State entities can sometimes not tell you what you need to know about insurance to be informed consumers.

The fundamental point of this is public/private partnerships, coalitions and coordinated resources can stretch whatever dollars are available much more significantly.

The second type of demonstration that's proposed is purchasing coalition. The essential element of this is to take what has worked in the under-65 market, group purchasing, group negotiation, and apply that to the Medicare market. To say that it can't be done is disingenuous. I point, for example, to the Minnesota Senior Federation with 30,000-plus members which has, in fact, already negotiated with networks and doctors and hospitals to accept assignment for all Medicare beneficiaries within 200 percent of the poverty level and also could easily get the waiver of copayments and deductibles. To say it can't be done is to ignore the facts.

The San Francisco Business Group on Health, which I think anybody would agree is a sophisticated purchasing entity, has wanted to do this for years. They are able to negotiate benefits for their under-65 market. They have the clout right now. They do not now have the ability to do that. To say that employers, AARP, unions, and other groups do not have the sophistication to do this, I think ignores the facts.

Now you can argue that there's a chance that this won't work. Clearly, some people are threatened by the fact that it might work and obviously some smart people think it can work. I think there's a tremendous cost -- there's a slight cost to doing the demonstration, we spend the money and it doesn't work. I think there's a major cost to not doing the demonstrations. We will not having any advance in knowledge and we'll be having the same discussion and the same debates five years from now.

So thank you for that. We had about one hour of conversation in this whole process with the MedPAC staff. I would really urge that the members of this commission read the report that was the basis of the Congressional mandate. Thank you.

MR. HACKBARTH: Thank you. We're not going to take further public comments at this point.

MR. ZESK: I was one of the people who was there at this meeting on the 17th, and it was not the same meeting that was characterized here today.

MR. HACKBARTH: Let me just say a word about the process here. Pardon me, as a rookie chairman, for being maybe a little bit uncertain about some of these procedural issues.

The nature of this commission is that we could never get our work done if, on every topic before us we had expensive public hearings. The amount of resources that we have, both staff resources and commissioner time, are such that we cannot proceed in that way. We would not be able to serve the interests of the Congress. We wouldn't be able to meet their requests.

So inevitably, we depend on the staff, an excellent staff in my judgment, to collect information, hold expert panels, in a variety of ways bring information to us and digest it for us. So we can't establish the precedent that we can't make a decision until we hear everybody in a room on each topic. I actually regret even cracking that

door just a bit a few minutes ago.

On this particular question now, moving from the general procedural point, we did get some materials this morning that at least I hadn't seen at this point. Two, as I recall. One from the National Council and then another that I'm not sure of the source. Oh, this is the summary, so it's just one additional document.

If members of the commission feel like they don't want to proceed to a decision at this point, we can take up a vote tomorrow. They can look at the documents that we got today and revisit the question. Is that how people would like to proceed? Jack?

DR. ROWE: There's a list here of the expert panel that the staff brought together. I have a few questions about it. One is I note that one of the members of it is a representative of the National Council on Aging, Howard Bedlan, or is listed as such.

The second is it's a little hard, from looking at this expert panel report, to get a sense of whether this was a 90/10 view or 55/45 view, in terms of where they came out with respect to the MCCs. It would be helpful to hear a little more about that.

Because the pros and cons are all listed here very nicely, but I don't get the sense of how the discussion was.

DR. ROSS: Jack, that was my mysterious reference earlier to Mary's point about consensus. 90/10 is a characterization. And I'll be candid, I was quite surprised going in. Given the diversity of the members of the panel, I would have predicted something much more even or -- that's overwhelming.

DR. ROWE: Fine. That's very helpful.

MR. HACKBARTH: So let's do this. People should look at the document that we received this morning. Then we will take this up tomorrow for a final decision.

By happy coincidence, Mr. Zesk, come to the head of the line.

MR. ZESK: First of all, I want to introduce myself. My name is Ed Zesk. I am the president of Aging 2000, a non-profit consumer organization based in Rhode Island that many people feel is a model for this Medicare consumer coalition concept.

I also am the secretary-treasurer of the National Coalition of Consumer Coalitions on Aging who are involved in helping to develop this proposal, and chair the committee

on Medicare managed care.

I also serve as a member of the Advisory Panel on Medicare Education that was created by the Balanced Budget Act to advise the Secretary of Health and Human Services and the Administrator of the agency formerly known as HCFA on issues relating to Medicare education.

I'm very disappointed and somewhat surprised at the recommendation from staff on this issue. I was actually at that meeting on July 17th and while I think there was a lot of questions being raised, some of those questions indicated that members of that group hadn't actually read the feasibility study. I won't disagree with the staff assessment that the majority of people were opposed to it, but I don't feel that adequate discussion and answers to some of those questions had an opportunity to take place. And I wish that some of the authors of that report had been there in the room at the time.

One of the recommendations, I've been asked by the fellow members of the Panel on Medicare Education, to chair the committee to draft our report to Secretary Thompson and Administrator Scully on the status of Medicare education currently in this country. And I have to tell you that the

situation is very bleak.

Information that we've received, testimony that we've received from places like Kaiser Family Foundation indicate that the majority of Medicare beneficiaries don't understand the Medicare program, much less the choices that are being offered to them. And that fully 50 percent of Medicare beneficiaries currently enrolled in managed care plans don't know that they're in managed care plans.

Now we think that the national Medicare education program is woefully underfunded, and that CMS has done a great job with limited resources in what it has been able to do. But the idea here of the Medicare consumer coalition is to leverage existing resources out in the community that not only can do a better job of helping Medicare beneficiaries understand the choices that are available to them in that marketplace in much greater detail than any centralized information source is going to be able to provide them, but also to protect the vulnerable populations. People with low literacy, cultural issues, language issues, who through coalitions of consumer organizations that already represent them, that they trust can be a source of information for them, that's going to help them make a truly informed

decision.

We're not there yet. We're not even close to being where we want to be on this issue. But unless we take advantage of those resources, there's never going to be enough money to do a fully adequate job.

Now on the issue of having the sophistication or expertise to be able to negotiate, on my board of directors are examples of the kinds of resources I'm talking about. I've got a retired bank president who was deputy treasurer of the state of Rhode Island, the former deputy director of health, the former chief policy advisor to the governor, a senior partner in the biggest law firm in the state, many physicians and nurses. Certainly the expertise is there to be able to represent consumers.

These kinds of purchasing cooperatives already exist. If you're a retiree of General Motors or if you're a retired member of a union, you've already got somebody using the buying power of your fellow members or your fellow retirees to negotiate with health plans.

Why is it that just because you're a Medicare beneficiary who didn't retire from the big corporation, or weren't a union member, that you wouldn't have access to

having that kind of leverage?

I would correct one point that was made before. This is a strictly voluntary purchasing cooperative idea. Anybody can join. And anybody can join at any time.

So in answer to the question of whether or not we could, for example in a state like Rhode Island, get enough people to join a voluntary purchasing cooperative that would allow us to sit down and negotiate for coverage, cost issues with health plans, Medigap insurance, long-term care insurance providers, and pharmacy benefit management companies, I assure you that we could. And we're not asking to do this around the country. We're saying let us do some very limited demonstration projects in selected communities where the ability is already there to do it, overseen by CMS.

Thank you.

MR. BEDLAN: Good morning. I'm Howard Bedlan. I also attended the meeting on the 17th. I'm the vice president for public policy and advocacy with NCOA.

First, I do appreciate the opportunity to comment before a decision is made. I think that's the appropriate process personally.

I do want to first respectfully disagree with the conclusion that it was a 90/10 split. I don't personally think that was accurate. I do think there were a lot of concerns that were raised, which is in large part the purpose of the meeting, so that those concerns could be put on the table. I think that a lot of the responses, in terms of how you design these, would respond quite effectively to the concerns that were raised.

I have not had an opportunity to see the Mathematica report so I can't comment specifically. But I do want to at least respond to what we have seen, which was the bulleted points earlier.

I would argue there are four issues that have primarily come up on the 17th, and from the presentation that we saw today. Number one is what is the value added of these kinds of coalitions. Number two was on the information side, how they might interact with the state health insurance programs. The third had to do with an issue that was debated quite a lot on the 17th, whether there would be a conflict if the same entity did the information and purchasing function. And finally, the stability and the numbers in terms of a purchasing

coalition.

In terms of value added, I do think, as my boss mentioned earlier, the fact that these would be non-governmental entities would certainly be a value added, in terms of their greater flexibility, the ombudsman and advocacy role that they would be able to take that SHIPs are not currently able to provide. I think the distribution networks of large coalitions would significant enhance the number of individuals who got good information.

While this could happen today, it's not happening for the most part. I think we need to think about why it's not happening.

Third, in contrast to the staff's conclusion, I think this would improve coordination. That's certainly the purpose. We would hope that this would be bringing together all of the different components and make it a lot easier and improve coordination significantly.

And finally, I think these could be used to leverage private dollars. The question was raised in terms of the funding. I think it's our view that we would be requesting some relatively modest startup costs. By virtue of having a broad base of organizations involved in this, we

believe that we would not have to rely upon government dollars for very long, and that we could eventually leverage other dollars, including some modest fees from individuals. We certainly would propose that those fees be waived for lower income individuals.

If you look at the one-pager that we did provide, and I hope you do get a chance to look at it before tomorrow, we do -- for example, on the information coalition side, propose two separate demonstrations for information coalitions. I'm quoting: "one that authorizes and funds the State Health Insurance Programs to form and lead the coalitions, and another that includes the SHIPs as members of the coalition along with other groups."

So we certainly recognize the important role that SHIPs would play. And we would argue that we need to test those two different kinds of models.

With regard to purchasing coalitions briefly, I do think there is experience out there right now. Minnesota Senior Federation is one example. Another group who is very interested in this is the Coalition of Wisconsin Aging Groups, who represent overall over 125,000 individuals. These are groups that have been around for a long time.

Minnesota Senior Federation began in 1973. Wisconsin Aging Groups was 1978. They are stable, they are certain. They have devoted members. They're well respected, and we do think they could do a great deal in this arena.

With regard to the adverse selection issue, let me just quote briefly from the feasibility study which was referenced. I think it's a legitimate concern, the adverse selection issue, by the way. "The track record with community-based senior organizations is that they direct much of their information and advocacy programs to the more vulnerable seniors. Hence, it's unclear whether Medicare consumer coalitions would form membership groups that are more or less healthy. Consumer coalitions can contribute to solving the risk selection problem by opening membership to all without economic barriers, keeping closer tabs on the health status and needs of its members, and exerting a countervailing consumer force to providers marketing to healthy seniors."

We would suggest that the information coalitions be separate and distinct from the purchasing coalitions.

And I think I would like to end with a quote from a Health Affairs piece from September/October 2000 that Dr.

Reischauer authored along with Len Nichols. "The question before policymakers is whether information about the consequences of alternative reforms can be gathered from carefully implemented and evaluated demonstrations. If not, reforms will have to be implemented cold turkey and disruptive adjustments and corrections will have to be made after the fact."

Thank you.

MR. HACKBARTH: Any other public comments? Let me emphasize that anything we talked about this morning is open to public comment. Any others?

MR. CONNELLY: Good morning members of the Commission. My name is Jerry Connelly, I'm with the American Academy of Family Physicians. I'd like to make just a couple of comments relative to the portion of your discussion this morning that applied to quality improvement standards in the Medicare+Choice and the traditional fee-for-service program.

I'd like to begin by underscoring one comment that Dr. Wakefield mentioned relative to collecting data only one time or at one intervention. I think that it's very important, when we talk about using this data that has

really been designed for clinical information, for outcomes purposes or other kinds of purposes such as measuring quality.

I think that it's important that we be careful not to overburden an already overburdened physician and supplier group. The information that you collect, not only should it be collected in my view one time, but it should be specific and it should be relevant to the patient care, the patient experience, to the quality of that care that is delivered. But beyond relevance, it should be valid and it should be reliable. Therefore, it should have some scientific basis and it must be referenced in the literature.

I think what we need to caution ourselves relative to the information that Dr. Reischauer mentioned, in that sometimes this data, as it is reported, can be interpreted inappropriately by the user or by the potential user, or people who have access to the information such as, in this case, the consumer. The improper interpretation of patient satisfaction information, for example, is well documented because in many cases -- or I should say in some, if not frequent cases, a patient has an expectation of receiving a certain kind of care that is not necessarily scientifically

valid and reliable. And when they do not receive that kind of care, such as an x-ray in the face of low back pain, or antibiotics in the face of a cold, then the patient satisfaction that is reported with that experience isn't as high as it would be had they received something that wasn't necessarily valid and reliable in the scientific information.

So I think that it's important not only to collect this information once, but at least pay some semblance of attention to those kinds of issues that I've mentioned here relative to reliability and the basis in scientific fact.

Thank you.

MR. HACKBARTH: Thank you. That's it for this morning. We'll break for lunch and we'll return at 1:30.

[Whereupon, at 12:51 p.m., the meeting was recessed, to reconvene at 1:30 p.m., this same day.]

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AFTERNOON SESSION [1:38 p.m.]

MR. HACKBARTH: Could our guests in the back of the room please have a seat?

MS. RAY: Good afternoon. We're here to talk about, for the next 30 minutes, payment for outpatient interventional pain management procedures. This study is in response to a Congressional mandate and is due to the Congress by December 22nd.

At issue is does Medicare's coverage and payment policies affect beneficiaries' access to outpatient interventional pain procedures that are performed in physician's offices, hospital outpatient departments and ambulatory surgery centers.

To assist us in examining this issue, we asked Project HOPE to look at these issues for us. Penny Mohr, who is a senior research director headed up the work. A draft report of their findings was included in your mailing materials for your review. She's here right now to present some of the major findings of her piece of effort.

MS. MOHR: Good afternoon. I'm presenting the findings from Project HOPE's study of access barriers to interventional pain management procedures among Medicare

beneficiaries.

As Nancy mentioned, the purpose of this study was to investigate whether Medicare payment and coverage policies for interventional pain procedures posed access barriers to beneficiaries. Of specific concern are the wide variations in payment rates and policies among different settings of ambulatory care, such as physician's offices, hospital outpatient departments, and ambulatory surgical centers.

To complete the study, we conducted a review of the literature, reviewed Medicare policies and procedures, and conducted interviews with more than 40 experts in pain management and Medicare policies.

Pain management spans a broad array of treatments, ranging from pharmacologic to surgical interventions. This study focuses exclusively on interventional pain management procedures. These are minimally invasive procedures, such as injection of drugs in targeted areas, or ablation of targeted nerves, and some surgical techniques such as the implantation of infusion pumps or spinal cord stimulators. They include such procedures as you may be familiar with as facet joint blocks, trigger point injections, and epidural

administration of morphine or steroids.

Many practitioners believe that interventional pain procedures are useful, both in the diagnosis and treatment of chronic, localized pain that does not respond well to other treatments.

Our discussions with pain management providers revealed a wide array of concerns about Medicare payment and coverage policies. Explicit in the legislation is the concern that Medicare's basis for establishing payment rates is not consistent across different settings of ambulatory care, perhaps introducing incentives to shift care among settings for economic, rather than clinical reasons.

Also, there is a concern that for some procedures in some settings payment rates may be inadequate. There are two underlying concerns that deserve mention here. First, some providers are concerned that office-based pain management providers are often grouped with facility-based physicians such as anesthesiologists when determining practice expensive allocations, resulting in a relatively low practice expense allocations.

Some providers have suggested this is because Medicare has not recognized pain management as a specialty,

even though it is a board certified subspecialty of the American Medical Association.

Second, there is a concern that under the new outpatient prospective payment system for hospital outpatient departments some interventional pain procedures were placed in inappropriate payment groups because there was a lack of cost data for these procedures. Many of these procedures are performed with fluoroscopic guidance, resulting in a multiple procedure bill. And as many of you may be aware, you've dealt with this issue in the past, that multiple procedure bills were not used for allocating procedures to ambulatory payment classification groups.

In addition to concerns about variation in payment rates across ambulatory settings, there's also concern about local variation in coverage policies among Medicare contractors.

And finally, there are some quality concerns. Without exception, all clinical experts that I spoke with stated that interventional procedures may have risk, although complications are rare. For example, inappropriate needle placement could result in paralysis or death. They raised a common concern that some of the physicians

providing these in their offices did not have appropriate surgical suite-like conditions and that some lack imaging equipment such as fluoroscopy which may be helpful to guide needle placement.

In our review we found there's no hard evidence that there are access problems, although there are many anecdotal reports of closures of pain management clinics. MedPAC's staff analyzed spending on interventional pain procedures in comparison with spending on physician services in general between the years of 1994 and 1999. With few exceptions, spending on these services has kept pace with that of physician services in general. That table was included in your report and is not presented here.

However, our ability to examine whether there were issues related to beneficiary access to these procedures was hampered by lack of data. For example, there's no central registry of pain management clinics, unlike dialysis facilities or ambulatory surgical centers. Pain management can take place in a variety of different settings.

Also, the lack of a pain management specialty code means we cannot confirm the procedures we identified in the claims data were explicitly used for pain management and

were not adjuncts to surgical procedures. Thus, our analysis of these data may mask access problems.

Also, many people we spoke to suggest the problem has been exacerbated in recent years and the most currently available data we have are from 1999. Therefore, although we cannot conclude there are access problems, neither can we confirm there are no problems with beneficiary access to these procedures. We need to know more.

We did find that there is some cause for concern about the manner in which Medicare pays for and determines coverage for these procedures. Many of these concerns are related to more universal issues that the Commission has dealt with in the past. For example, payment rates do vary widely across ambulatory settings, as shown in the slide. Here we present just three examples. Comparisons for all other procedures are in your report.

In the slide here we see that payments for some interventional procedures in an ambulatory surgical center are nearly twice as high as they are in an HOPD. Also, the practice expense payment is generally lower, despite the fact that physicians must maintain operating room types of precautions to safely perform these procedures in a

physician's office.

There are also many legitimate concerns related to payment and coverage of these procedures in ASCs, and I would like to spend a little bit of time going over these. First, there are a large number of interventional procedures that are not on the ASC approved list. Only 46 of the 85 interventional pain procedures we identified were on the ASC approved list. This is partly due to the administrative delays in updating the approved procedure list, and partly due to the way in which CMS determines which procedures should be on the approved list.

The approved procedure list has not been updated since 1998, despite rapid technological advancement in medicine. CMS determines approved and excluded procedures for ASCs according to the percent volume in which these are done at specific sites -- like physician's offices versus ASCs versus inpatient -- analyzing Medicare claims data. Specific to interventional pain procedures, CMS determined a growing number of interventional pain procedures were being provided in physician's offices and thus determined that they could safety be performed in that setting and should not be on the ASC approved list.

Providers counter that many of the procedures excluded from the ASC approved list do require operating room type precautions. Also, there have been delays in conducting cost surveys to update payment rates. The ASC cost survey has not been fielded since 1994, despite statutory requirement that it must be performed every five years.

The fact that ASCs are paid on the basis of eight payment groups rather than the more extensive categories using HOPDs or physician's offices means that CMS is paying the same price for procedures with potentially widely varying costs.

Finally, there are wide discrepancies in what ASCs receive for the same procedure because of varying interpretations of regulations. ASCs are required to provide only those procedures that are directly and integrally related to the performance of outpatient surgery. Consequently, payment for some adjunct procedures like fluoroscopy or durable medical equipment are supposedly bundled into the payment rate. But CMS also says that ASCs may wear many hats.

For example, if an ASC becomes a licensed supplier

of durable medical equipment or a licensed independent diagnostic testing facility, they may bill separately for these items. This statement is in direct conflict with 1999 safe harbor regulations which state that all ancillary services in an ASC must be an integral part of the procedure and cannot be billed for separately.

The bottom line is that some ASCs are receiving nearly $7,000 for the implantation of an ambulatory pain pump, while receive only $433.

We also found problems with inconsistent coverage policies among Medicare contractors. Most coverage decisions are made by private insurance companies Medicare contracts with to process claims. Because of the large numbers of entities involved in making coverage decisions, inconsistencies in policies are common.

Not only do policies vary across localities, but a single hospital can face conflicted policies because a carrier determines polices for an ASC while a fiscal intermediary determines policies for the HOPD. However, a hospital may own both an ASC and an HOPD.

To illustrate some of these differences we examined local coverage policies for paravertebral facet

joint blocks. We found that many carriers have imposed limits on the number of these procedures that can be performed in a given day. These limits vary from only two facet joint blocks on the same day to no limits.

We must say here that there is no good evidence what the appropriate number of these blocks should be, and I'm going to discuss that in a little bit.

We also found wide variations in diagnoses covered for this particular procedure, and also there were variations in the requirements for the use of fluoroscopy. Some Medicare contractors specifically state that they will not pay for this procedure unless it's performed in conjunction with fluoroscopic guidance, and others make no statement on the issue.

When we think about policy options, we find that CMS is addressing many of the issues that were raised by providers. For example, CMS granted a Medicare-recognized specialty designation for pain management last month which will take effect in January of this year. Also, a proposed rule for hospital outpatient PPS, issued in August of this year, creates several new APCs for interventional pain procedures and mitigates many of the concerns providers had

raised regarding payment in that setting.

CMS is also continuing to improve the openness and evidentiary basis of its coverage determinations used both nationally and by its contractors. For some of the issues that are not being addressed, we raise some policy options to consider. One of the common themes we revealed in the study was that the quality of scientific evidence available on interventional pain procedures is lacking. This is not uncommon for medical science in general but it is very true in interventional pain procedures.

For example, in a recent meta-analysis completed on injection therapy for subacute and chronic low back pain conducted by the Cochran collaboration they concluded these procedures are not yet shown to be effective, nor have they shown to be ineffective. We need to know more.

CMS has established precedents in jointly sponsoring clinical trials with the National Institutes of Health and pain management may be a ripe area for further joint sponsorship of these types of trials.

Medicare has also established precedents in the use of provision coverage where investigational procedures may be covered if beneficiaries receive treatments at

facilities that are following a rigorous study protocol to evaluate the outcomes of care. One of the clinicians we interviewed for this study recommended that provisional coverage would be an excellent vehicle for gathering better data on many of these procedures, particularly in examining how many of them should be covered in a given day or over a period of an episode of treatment.

For example, Medicare contractors could continue to retain their restrictive limits on the number of facet joint blocks that are done in a given day but would pay for more as long as they were done in the context of a rigorous controlled study, so that data can be gathered to better guide Medicare policies in this area.

Although not explicitly a recommendation for a change in federal policies, specialty associations could also help CMS set better policies in this area with the development of cost specialty guidelines. Although there are many guidelines in the area of pain management, they are not always consistent. Cost specialty guidelines could help CMS and its contractors better understand such issues, for example as to whether fluoroscopic guidance is necessary for a particular procedure. They may also help establish

minimum quality standards for the performance of these procedures in physician's offices.

Finally, there are many improvements that can be made in Medicare payment and coverage policies in ASCs. Some of the changes made in the proposed 1998 rule are suitable policy options for addressing ASC issues that we've raised. For example, inconsistencies between ASC and HOPD payment could be diminished by converting ASC procedure classifications into a more extensive grouping based on clinical aspects in addition to costs.

Also, if CMS moved toward discontinuing site of service requirements as a primary criterion for approved list it could help allay some of the concerns.

CMS should also implement a more expeditious timeline for updating costs and devising an approved procedure list.

And finally, there needs to be a movement to resolve the conflict between the safe harbor provisions and policies for billing for DME and adjunct imaging in an ASC.

Thank you very much.

MS. RAY: Based on the findings from the Project HOPE study and staff's review of the evidence we propose one

recommendation for the Commission to consider. This recommendation addresses the need for research on the use of outpatient interventional pain procedures among Medicare beneficiaries. Additional research in this area should help both CMS and its carriers in setting payment and coverage policies and it should also help providers in ensuring that they are delivering high quality care to beneficiaries.

We'd like your input on the draft report submitted by Project HOPE, our conclusions, and the draft recommendation.

DR. NEWHOUSE: Can you say a little bit about why there's not more in the way of draft recommendations, given all the material in the report about payment system?

MS. RAY: Right. Well, I think the issue is why we didn't present a draft recommendation specific to the ASC payment policies.

DR. NEWHOUSE: And the updating of the procedures and so forth and so on. There's a whole litany here.

MS. RAY: Right. Again, these problems have been raised in the context of interventional pain management procedures. We thought that there are clearly issues here but they need to be more broadly looked at from a higher

level perspective, not just interventional pain procedures.

DR. NEWHOUSE: I certainly agree with that, but I don't know that there's any reason we can't say something about these in this context and note that they go well beyond pain management. Issues like provisional coverage go well beyond that.

MS. RAY: Yes, and we certainly were planning on doing that. We just didn't want to make it into a -- staff didn't propose it as a recommendation because of the fact that this is a narrow report.

DR. NEWHOUSE: I'm not sure I'm comforted by that. I think we should have a recommendation, but if we don't I think it's incumbent on us to say why we don't, given all that's here.

DR. REISCHAUER: Just on Joe's point, I would agree with you completely. I think there seems to be enough smoke here to talk about the fire in rather explicit ways.

I was interested in how you went about trying to answer, is there enough of this pain management going on? One of the metrics you used was, the spending that we do for this has grown about what spending for other physician services have been. That, of course, presumes several

things. One is that it was right the first time, and secondly, that the rate of growth of these two things is about on target.

I was thinking of other ways we might address that problem. One would be looking at the literature on what's the optimal amount, and you say there's nothing -- it's confused.

The second thing would be to go to a different set of patients who are under, let's say an employer-sponsored plan who have the same kind of condition, cancer or whatever it is, and different payment procedures that are viewed as more appropriate, and see what their utilization is versus Medicare's.

A third would be to look at the experience in some other countries and see the extent to which we rely on these types of interventions versus the Swedes or whoever is at the cutting edge of this.

Even if we did then find that we don't have enough interventional pain management going on for "optimal care" the question would be, why? One possibility, of course, is the one you examined, the Medicare payment system. But another is reluctance on the part of physicians or lack of

knowledge on the part of physicians to pursue this avenue. And a third is patient preferences.

How we would disentangle all of that, if we could -- I don't think we can --

MS. MOHR: Can I just make one comment there? I've long been interested in the issues of international comparisons of the use of medical technology. I think that the problem is that when you look at that you can see variations and you can't say, is it too high or too low? It's very difficult to know what's appropriate. I think that's the question that's not answered right now.

We can make some comparisons across different groups but it's very difficult to know what's appropriate because we don't have enough evidence there.

DR. ROWE: I think one of the additional considerations that makes the utilization comparisons less reliable is that this is really an emerging technology in many clinical areas around the country. There are areas in which this is widely accepted by practicing physicians, and they refer patients for this kind of procedure, and there is a center of excellence in the area and utilization might be quite high. Then I think there are whole areas of the

country where there's very little utilization of this because there just haven't been people trained in it, or the practice in the community has not yet adopted the utilization of these procedures.

So we're in that early phase of heterogeneity of some early adopters, et cetera. That would complicate some of the comparisons because the early adopters may be over-utilizing. That might not be the right -- and the late adopters may be under-utilizing. It would be hard to know what the right number I think.

MS. MOHR: My understanding is that these procedures have been around for a long time.

DR. ROWE: I agree with that.

MS. MOHR: But you're right, their use has been increasing in recent years.

MS. BURKE: I wanted to just go back for a moment to Joe's point, which I agree with entirely. But to query just a little bit, is there any aspect of the policy options that were proposed in the study with which you disagree? I mean, your decision not to be more fullsome in terms of a specific recommendation, I wondered whether there was any aspect of this with which we had substantive disagreement?

Whether your decision not to go further in terms of detail was based on a fundamental disagreement or just your thought that it wasn't what you were charged to do? I'm just trying to understand why we limited ourselves to a relatively brief reference to the need for a study on effectiveness.

MS. RAY: No, I don't in general disagree with any of the findings from the Project HOPE report or the conclusions or the policy options. I think that there may be additional payment issues out there with respect to ASCs. That if we're going to start making recommendations about ASC payment policies we should do it by looking completely at the ASC payment system, and there may be issues here that we're not taking on here. That was my mind-set in just going with this one recommendation. But having in our letter that will accompany this report to the Congress stating there our concerns about ASC payment policies and reiterate the findings from Penny's study.

MS. BURKE: I guess my only cautionary note is as I understood the intention of the study it wasn't specific to ASCs. It was specific to the issue of interventional pain management.

MS. RAY: That's correct, right. The other

potential, I thought, recommendation that could also be made was the one about the different payment policies across HODs, physician offices, and hospital outpatient departments. Now MedPAC has already made a recommendation about that, and that was in our March 1999 report. Again, what I was planning on doing the next time around for this is to reference that and reiterate that.

Now if the Commission feels very strongly about that and would like to make that again as a formal recommendation then I can come back and provide that.

DR. ROSS: Before you promise the store here, I think Nancy's main point there is exactly on point, which is if we want to talk about payment consistency and other kinds of issues we should do that in a large, and not build up from particular sets of procedures.

I was just jotting down three issues, all of which amount to, go slowly here before looking for doing too many recommendations. One is, there's a basic issue of, does this work or not, that precludes fine-tuning payment policies for specific codes and specific settings.

There's a second issue relating to how far the Commission wants to go digging into coverage issues

generally. That's just a resource constraint problem, given the depth of -- how far do you want to go given all the many other commitments that we have? You collectively need to make a decision about that, but my view would be caution.

But I think first things first on this one. There's an efficacy and appropriateness issue. To the extent there's payment system issues we should address them in the larger OPD-ASC-physician office issue.

MR. DEBUSK: Are we talking about efficacy or a degree of efficacy?

DR. ROSS: Degree of.

MR. DEBUSK: We know it works in a lot of cases, and there's a reason for it being there.

DR. ROSS: When I say efficacy, I mean in the sense that, as Penny said, you can't tell if there's an access problem out there. We have no evidence that there is or there is not. How far do you want to go on the basis of that finding, then to start fine-tuning the fee schedule, given that piece of evidence? That's what should be established first.

DR. LOOP: I think this is a very comprehensive report. I really enjoyed it. I think that there's probably

three areas of recommendation that you could make though. One is the effectiveness of the procedures. But we're beyond whether it's effective. It's certain types of procedures, are they efficacious? For example, do implantable pumps reduce future interventions and decrease the cost? That's the kind of research that ought to be done.

But the other two recommendations are, one is, fix the inequities, fix the variations in payment, and the third is safety. Because there's a lot of perverse incentives for people to move these procedures into their offices where there's very poor guidelines, there's the wrong kind of people doing these procedures. I think safety should be somewhere in our milieu of recommendations. So I agree that we should expand the recommendations.

DR. NEWHOUSE: Murray, I don't disagree with you very often, but I disagree with you on this one. First of all, I don't think we're going to fine-tune the system. I think we're going to recommend some attention to the system.

Second, saying it's going to be done in the context of the entire system might take -- the point, that may be the best. But here I think the best is the enemy of

the good, because I don't think it's going to happen for a while. This seems sufficiently high priority to me to go ahead and start in on it.

MR. HACKBARTH: Any other comments? From a process standpoint, Murray, do you have a recommendation on how we proceed here? Were you hoping to get this resolved today or is this something --

DR. ROSS: I'm always hoping for early rather than later resolution. We hear you. We'll craft some recommendations and supporting language and bring it back to you in November.

MR. HACKBARTH: Maybe this is strictly academic. Maybe it shouldn't be cast necessarily as a recommendation. Sometimes in these reports don't we just make observations about what we find? I think we could make observations that there is missing evidence about effectiveness. That we do see these disparities among payments that could be problematic. It seems like there's a lot of unanswered stuff here. We can point in the general direction.

I generally don't like this sort of recommendation. The Secretary should pursue additional research doesn't say a whole lot to me. I'd rather maybe

make some statements of finding. This is what we find. These are the questions that it raises in our mind, but given the lack of information or the developing nature of this field it's difficult to be definitive.

DR. ROSS: Could I give a counter-example? You could phrase as a finding or a recommendation something to the effect of, we observe substantial disparity in the payment rates for these services. The Secretary should investigate this. Of course, the Secretary is in fact also the person who set those payment rates and presumably did it on some basis in the first place.

You get a little bit circular here. If you want to point to some issues and say that the Commission is concerned about these -- I don't know how specific we can get on that.

MR. DEBUSK: Why don't we think about this for about 30 days and come back and revisit this? Because I think there's more here than we --

DR. LOOP: One thing you could put in the report which might get the Secretary's attention is the growth of these procedures, because it's rising as fast as any subspecialty procedures in the U.S. By the way, I don't

think any international comparisons are worth doing because I think we're way ahead of most other countries, don't you?

MS. MOHR: I would say so.

DR. NELSON: I'm unclear in my mind about what kind of help Congress was seeking from us when they punted this to us. So Glenn and Murray, when you come back to us, frame the question that Congress wanted us to help answer. Somebody went to them with some case to make for some inequity or some failure to pay what was, in their mind, appropriate, and Congress punts it to us. I think we at least ought to try and get close to answering whatever question was being posed.

MR. HACKBARTH: Okay. Thank you, Penny.

MS. RAY: Okay, so now the next policy question before us. Do cancer hospitals face special circumstances that make the outpatient prospective payment system inappropriate for them, and should cancer hospitals continue to receive hold harmless payments that serve to protect these facilities from losses under the outpatient prospective payment system? This work responds to a congressional mandate that MedPAC look at the applicability of the outpatient prospective payment system for cancer

hospitals. The report to the Congress is due around December 1st.

The Commission has already looked at a similar issue in our June 2001 report when we looked at the appropriateness of the outpatient prospective payment system for small rural hospitals. In our report we concluded that rural hospitals are more vulnerable to the financial risks inherent in the outpatient prospective payment system and may have fewer resources available to manage those risks. The Commission recommended that the existing hold-harmless policy for these small rural hospitals be continued until better information becomes available. Our study on the small rural hospitals was also in response to a congressional mandate.

Just a brief review of how the current payment policy works. Cancer hospitals, they are the only class of hospitals -- cancer hospitals and children's hospitals, but we're focusing today on cancer -- are the only class of hospitals for which financial protection from the effect of the outpatient prospective payment system is permanent. The BBRA protected small rural hospitals with 100 or fewer beds from financial losses but only through calendar year 2003.

Rural hospitals with more than 100 beds and virtually all other hospitals receive transitional payments through 2003 if they are paid less under the prospective payment system than they would have been paid under the pre-PPS rules. However, unlike the cancer hospitals, they do not recoup the full difference and the extent of additional payment declines between now and 2003.

To summarize our findings, staff found evidence showing that cancer hospitals do have a narrower service mix, higher unit costs, and poorer financial performance under Medicare. However, we were unable to analyze claims data from the post outpatient PPS period to examine the extent to which cancer hospitals receive hold-harmless payments. CMS has not made those data available yet because of validity concerns.

So what did we find specifically? One of the reasons we might think that cancer hospitals are more vulnerable to the financial risks of prospective payment is that a larger share of their outpatient revenues is from Medicare than other hospitals. This increases their exposure to the financial risks inherent in prospective payment. This does appear to be the case. Cancer hospitals

outpatient share within Medicare is 32 percent compared with 14 percent overall.

In your mailing materials there was a table showing differences in the types of services cancer hospitals provide on an outpatient basis than other hospitals. The impact of these differences in service mix on the financial viability of cancer hospitals under PPS depends on the adequacy of payments for each type of service. Again, we don't have hard evidence to date. At issue is whether the outpatient prospective payment system is appropriately paying for the mix of services provided by cancer hospitals.

There is some concern that in the method CMS used in developing the outpatient prospective payment system that it may not appropriately pay for these services. For example, the use of the median values resulted in lower payments than mean values when CMS was developing the relative weights. This may affect cancer hospitals disproportionately compared with other hospitals, as I'll show you on the next slide, because they do incur higher costs on average than do other hospitals.

Again to repeat a finding that we just talked

about under the pain management study, CMS excluded multiple procedure claims to reduce the risk of improperly assigning cost to the wrong service. Excluding multiple procedure claims could skew the calculation of APC weights if hospitals with higher costs are more likely to submit these claims. Some preliminary evidence does suggest that this is the case.

CMS reported that cancer hospitals' unit costs are about 20 percent greater than other hospitals. CMS solely attributed this finding to the under-coding of services in the pre-outpatient claims data.

We offer several other reasons for your consideration why these hospitals may incur higher unit costs. One of them being that they appear to be treating patients of higher acuity on average than other hospitals. Secondly, that they do provide enhanced patient care. What I mean by that is their role as a national cancer institute, coordinator center, their involvement in clinical trials, their use of cancer protocols using state-of-the-art treatments as well as providing free services related to cancer screening.

Cancer hospitals cannot offset their outpatient

losses with inpatient revenues. Cancer hospitals don't have the same ability because they are not paid under the acute care prospective payment system for inpatient services. Rather, they are paid under TEFRA. Under TEFRA, cancer hospital payments for inpatient operating costs are based on each facility's Medicare-allowable inpatient operating costs, subject to a limit based on a target and Medicare operating cost per discharge.

So we have presented some tables for you in your mailing materials on the Medicare inpatient-outpatient and Medicare total margin. Before the introduction of the outpatient prospective payment system, cancer hospitals had lower Medicare outpatient margins, for example, in 1999, compared with other hospitals, including major teaching and other teaching hospitals. The inpatient margins for cancer hospitals were negative in 1997 through 1999. These data are presented for other hospitals in your mailing materials.

So based on this evidence that we uncovered about the higher unit cost, the narrower service mix, the lack of ability to offset outpatient margins with inpatient revenues, and the lack of outpatient claims data for the post-PPS data, staff offer the following recommendation for

the Commission to consider.

DR. NEWHOUSE: I'm fine with the recommendation. I have one suggestion and one observation. The suggestion is a small one. Could you tell us somewhere in the text -- if you know it now -- what the total dollars Medicare spends on cancer hospitals are? That, I think, would help put this in context.

MS. RAY: I can get that for you.

DR. NEWHOUSE: And the observation is that this table you show us on page 16 that has the margins, it looks to me like there's a problem on the inpatient side as well. The margins go minus three, minus five, minus seven, from '97 to '99. It looks to me like we need to consider what would amount to re-basing the cancer hospitals on the inpatient side as well. Again, this was sort of the dog that was in the report that didn't bark, and the recommendation.

DR. ROWE: I had several comments and questions. I gave Nancy and Dan a little pre-warning about some of my questions so they might be prepared. Some of you who have been on this group for a while are familiar with my point of view with respect to cancer hospitals and I won't bore you

with a recitation of that.

But I do find certain aspects of the document to be an apologia for the very well-developed, very well-funded, very effective cancer hospital lobby. I don't accept the view that cancer hospitals systematically treat sicker patients. In fact I believe that the general hospitals that have larger cancer patient populations treat sicker patients because they have patients who have heart disease, diabetes, and other problems, where they have cardiologists, and they have gastroenterologists, and other people on their staff rather than just cancer specialists.

The general hospitals tend to treat older patients with more comorbidities, et cetera. To suggest that state-of-the-art care is available in these 11 hospitals suggests it isn't available in the other hospitals, such as the Cleveland Clinic or the University of Chicago Medical Center, et cetera, where there's just as much, if not more, NIH support, and there are in fact just as many NIH-supported centers, and so on.

So I have a concern about that. I would like the document to be re-read with respect to that general point of view.

With respect to the specific issues here, there are 11 of these cancer hospitals, and they vary dramatically. My understanding is the one in Boston is not even a hospital. It is an outpatient clinic. All the beds are in the Brigham. So it's not a hospital. That's the Dana Farber. Then there are others where there are very large inpatient programs and very small outpatient programs.

So the estimates we see with respect to the proportion of revenues that are outpatient don't share any estimate of variance around those numbers. I would submit that there's a subset of these hospitals that are very much like general hospitals with respect to their inpatient-outpatient mix, and therefore don't necessarily need special treatment respect to their outpatient reimbursement. And there are others that really are very much at risk.

Most people who run large hospitals -- Ralph is not here but I think he would support this if he were -- lose money on the outpatient and make money on the inpatient. That's generally the way it works. And if all you have is outpatient, that's not a good design with respect to that.

So I would propose that we might get more

information than we get from that mean number by looking at the variation within this group. There may be two subsets.

Another thing I would say, which really gets to Joe's point about the negative margins, is that the chapter deals with Medicare margins. Sometimes it says Medicare margins and other times it just says inpatient or outpatient margins, but it means Medicare margins. I submit that these hospitals have higher proportions of patients who are private pay, that come from outside the United States, and that their overall margins may in fact not be reflected by their Medicare margins. So that we may not have a complete view on the data with respect to this.

So in summary, my view is that I'm very sympathetic to the need for those institutions which are disproportionately disadvantaged by the nature of their inpatient-outpatient mix to -- we don't want them to be disincented to take care of Medicare beneficiaries because they do provide excellent care. It is state-of-the-art, as is available in other places. So we want to incent them to take care of our beneficiaries.

I think we should do something about those institutions. But I don't think that that necessarily means

all of these institutions, and I don't think that the Medicare margins, per se, accurately reflect necessarily the overall performance of the overall institution.

MR. HACKBARTH: Nancy and Dan, did you have some response?

DR. ZABINSKI: Just a few comments. On the variation, there is a fair amount of variation on the outpatient margins. But I would say there's even more variation on the inpatient margins.

DR. NEWHOUSE: I thought Jack meant on the share of the revenue that was outpatient, not the margin.

DR. ROWE: Right.

DR. ZABINSKI: That, offhand, I don't know.

The total margins that you referred to, I ran those numbers like three months ago and I don't recall if I really vetted those, really said that these are okay. I mean, I remember I ran them and I remember the results are actually pretty reflective of the overall Medicare margins we have in the paper. But I can't say I would put a lot of faith in it at this time because I don't recall if I really okayed them or not.

DR. ROWE: They are what they are. But I think

that it might be helpful to have them.

MS. RAY: I just want to add one thing, just to follow up on Jack's point. It is correct that overall Medicare accounts for a smaller percentage of their revenues. Again, just looking at the 11 total. It's approximately 17 percent versus overall for all other hospitals, 30 percent.

MR. HACKBARTH: So, Jack, your point of view, in a nutshell, is maybe the category defined is too broad and includes actually quite dissimilar institutions. And for some subset the arguments raised may be valid, but we shouldn't just buy it because it's labeled a cancer hospital.

DR. ROWE: Right. I would say two things. One is I'm very interested in making sure there's no disincentive with respect to our beneficiaries in Medicare having access to the services of these institutions. These are wonderful institutions. I just don't like the idea that they're the only wonderful cancer treatment options in the United States, which is sometimes what you year. So that's number one.

Number two is, I would suggest that maybe what we

do is say, for those institutions in this category that have a substantially higher -- pick a number, whatever, I don't care -- proportion of their Medicare revenues that are outpatient, that they should be eligible for this special treatment. But in fact they don't, then I think the argument falls apart, and then I wouldn't give it to those.

DR. NEWHOUSE: The problem I see with that, Jack, is that could well be true, and probably is true, for other hospitals.

DR. ROWE: I understand that. That's why I don't think should be a special group at all. But here we are. It's a special group.

DR. NEWHOUSE: But then the next group we'll hear from will be the short term general hospitals that have a high outpatient revenue.

MR. HACKBARTH: We did hear from one subgroup of those, the rural hospitals, who had, in some way, similar conditions where a disproportionate share of their revenues came. And we in fact reached the recommendation that gives those conditions we ought to be very careful about the application of outpatient PPS. So I don't think we would be breaking new ground to say, for hospitals that have these

conditions, we need to be careful, as opposed to hospitals that bear the label cancer hospital as applied by NIH.

DR. REISCHAUER: But there is a difference and that was there weren't alternatives with respect to the rural ones. What Jack is saying is, they're wonderful, but there are other wonderful places a few blocks away.

MR. HACKBARTH: Actually, that's a good question. I don't remember off the top of my head that that was key to our rationale in talking about rural hospitals. I think it was more that they were unusually dependent, and therefore, at risk. It wasn't because they were sole community facilities. We didn't say, only sole community rural hospitals we ought to be careful about outpatient PPS. We said across the board.

DR. REISCHAUER: No, but that's because with the word rural comes an understanding --

DR. NEWHOUSE: Also, is it clear that in fact things are fine on the inpatient side? Obviously these institutions are existing so they're making it somehow. But our general philosophy -- I don't recall immediately the rural margins on the inpatient side, but it seemed to me -- the Medicare margins, they looked better than what we're

seeing here.

DR. WAKEFIELD: They were negative also.

DR. NEWHOUSE: But not as negative as this. I'm not even sure they were negative.

DR. WAKEFIELD: I can't remember, but both were negative. Their overall margins were higher, their inpatient and outpatient, and Medicare overall were lower.

MR. HACKBARTH: Jack's comment resonates for me personally because, for example, when we did the testimony on the rural report, one of the themes was that we want to target relief. We want to adjust payment systems so that they appropriately reflect efficient cost. We want to depart from these big labels and say, let's just give more money to all rurals. We systematically rejected those options for more targeted ones.

It seems to me what Jack is saying, that same way of thinking applies here. We've got a big label that in fact covers disparate institutions. Let's couch our recommendation in terms of particular conditions. If a given cancer hospital has them, fine. But if they don't, we ought not give them the relief. To me that's one of the cardinal principles of MedPAC policy and world view.

DR. ROWE: I think that reflects what I'm saying. I certainly don't want to be interpreted by anyone as saying, because I've got this thing about this category, that I don't want to help these elements in this category that need help. They do it. They're great places. The last thing I want to do is have anything to do that leads to Medicare beneficiaries not getting access to good care. I just think we need to be a little more targeted.

MS. BURKE: If there are only 11 of them, and Dana Farber, which is a strange circumstance, how big is the variance among them?

DR. ZABINSKI: In terms of what?

MS. BURKE: Inpatient versus outpatient. I mean, the variance among rural hospitals is considerable in large part because there are a considerable number of rural hospitals who have very different circumstances. How varied are, in fact, these hospitals for which this special exclusion applies?

DR. ZABINSKI: Not certain.

MS. BURKE: Do we have any idea.

DR. ZABINSKI: Not right now.

MS. RAY: We can find that out.

DR. ZABINSKI: That's real easy to come up with.

MS. BURKE: I think Jack raises a very good point. We ought to have some sense of how widely variable they are. My guess is there may be a couple of outliers but they may otherwise be consistent. Whether M.D. Anderson and Sloan -- I mean, I don't know the answer to that question. But there's certainly a much smaller universe so you've got to assume there has to be --

DR. ROWE: If we could at least just see that table. Maybe I'm wrong, in which case, fine. That's fine, too.

MR. HACKBARTH: It seems to me that's the immediate next step. Jack has framed some questions that require digging a little bit deeper on the data. Let's take a look at that. Murray appropriately points out, the way the recommendation is couched is, until we have better data. We may conclude after the next meeting that there are still more questions that we want to ask. The thrust of this is, let's err on the side of not making a big mistake until we can target adjustments or relief appropriately. That's certainly something that I can endorse.

Nancy and Dan, any questions about what we're

asking you to do?

DR. ROSS: I guess one question is, Dan, how quickly could you come back to us with something? Is this a set of facts you can bring back tomorrow?

DR. ZABINSKI: Yes.

DR. WAKEFIELD: Have a good evening, Dan.

[Laughter.]

DR. ROSS: In return for one Thursday evening, he might get a whole month, is what I'm trying to --

DR. ZABINSKI: No, it wouldn't be a big deal.

DR. ROWE: So is it clear what we want?

DR. ZABINSKI: I get the idea that you want a table that shows the variation, the proportion of revenue that comes from outpatient. You want to look at total margins.

DR. ROWE: You could even, if you have it, because you have to have it in order to get -- just list them, A through K, and then what the mean is. Then it will be obvious.

DR. ZABINSKI: I've got basically two tables.

DR. ROWE: Don't put their names. Just put A to K.

MS. RAY: We can do that.

MR. HACKBARTH: That would be very helpful, Dan, and we'll figure out where we can put it in tomorrow's --

DR. ZABINSKI: I can be back here in an hour if you want me to.

MR. HACKBARTH: Come back tomorrow. Any other questions about direction? Jack is up next, right? Assessing payment adequacy.

MR. ASHBY: In this session we're going to lay out a proposal for revising the way that we update payments across all sectors in fee-for-service Medicare. We see problems, or maybe I should say at least three problems, in the process that we have been using to date.

First, we have tended to mix consideration of the adequacy of the current rates with the update needed for next year. At times that has caused considerable confusion.

Second, we have tended to focus on narrow issues, like how many tenths of a percent should be ascribed to the Y2K problem, or whether the cost of new technology is greater than expected productivity improvement, while at the same time devoting little attention to whether the current rate really is associated with efficient cost of care, which

is an issue that could have far greater financial implications.

Then third, to the extent that we have considered payment adequacy, it has been in the form of attempting to measure individual factors that may have produced the imbalance. Things like unbundling, forecast error, upcoding, and the like. Given the difficulty of measuring those individual items, it seems like it might be better to focus on the outcome which is, is today's base rate the right one, regardless of how we got where we are.

As an example of the problem, the issue we're dealing with, the Medicare margin for inpatient services over the last decade has ranged from minus two to 17. That is a huge range. The industry representatives have tended to stress that payments have gone down since the BBA relative to cost, and they have. But that implies that the peak point as of 1997 is the right one, and no one ever said that, or at least no one from Congress or the Medicare program ever said that.

For our part, we have tried to fill out the picture a little bit showing that that decline was preceded by an even larger increase. But again, that might be

construed as implying that the trough point, which was 1992, was the right one. Again, no one really ever said that. The unanswered question the whole time is, what is the appropriate level of payment? That's the question that we really would like to focus on.

Many have suggested that the task of deciding how money ought to be in the system is practically an impossible one. That may be true, but we would like us all to remember that Congress and CMS implicitly make decisions about the appropriate amount of money in the system quite frequently. CMS decides the overall level of payments ever time it launches a new PPS. It usually sets aggregate payments equal to current aggregate costs, but not always. Recently in starting the SNF PPS, for example, they set the initial payment rate below current cost.

Congress make payment adequacy decisions. A couple of examples are the 15 percent cut in home health payments that is still looming in front of us, contemporary 4 percent increase in SNF payments. In fact one could take the stance that there is an implicit payment adequacy decision involved in every update that is promulgated.

So the point here is that if explicit decisions

are not made, then implicit ones will be. Our thinking is that perhaps the Commission's judgments could help Congress in making those final payment level decisions.

With that premise in mind, we are proposing today a model where the annual updating process would routinely be divided into two steps, a two-step process. As we see in this first overhead, the first step would be assessing the adequacy of the current base rate, which would hopefully result in a stated conclusion about whether payments are about right, too high, or too low, and then a recommendation for adjusting that base payment rate as applicable.

Then the second part of the process would be determining an adjustment that accounts only for factors expected to affect provider's costs in the coming year. Then the final update as depicted in the figure here simply combines the two percentage changes.

In the remainder of my presentation I'm going to focus on the first part of this process, the basic payment adequacy. Then Nancy Ray will be back once again to take on the second part of this process. What I'm going to do is review three generic steps in the payment adequacy assessment process, take a look at several factors that

might be considered in assessing payment adequacy, and then discuss several related issues, we might call them complications, that may arise in the process.

So let's go on to the next overhead. This depicts the basic process. The three steps involved are very straightforward conceptually. The first step measuring current Medicare payments and cost is nothing more than documenting where we are at the beginning of the process; how much money is in the system. I would point out though that in the case of physicians we don't have any measurement of cost. All we can do is measure the amount of payments. It doesn't take away from the model. It's equally applicable. But we have the constraint that we don't have cost data to deal with, so we have to go as best we can with that process.

Then the second step is determining where we want to be, how much money should be in the system. And the third step is devising some sort of an approach for getting to where we want to be. Now I have a couple of comments about the first and third steps a little later, but right now we want to focus on the middle step, which is indeed where the action is.

One of the important things to understand about assessing payment adequacy is that it's actually a two-step process, connoted by the two bullets in that middle box. We would be looking, hopefully separately, at the appropriateness of current costs, and then at the relationship of payments to cost. A couple of examples I think is maybe the best way to appreciate the difference between these two looks.

When ProPAC and MedPAC several years ago called for a series of negative adjustments to inpatient payments for unbundling following this massive decline in length of stay, while we never said this explicitly, I think it's fair to say that the Commission didn't really have any quarrel with current costs. The problem was that payments were too high relative to those costs.

But when CMS a couple of years ago set the initial base payment rate in the SNF PPS below current cost, it conversely was really saying that they thought costs were too high and they were looking to establish an incentive for providers to bring down those costs. We wouldn't want that to be interpreted as they thought payments ought to be less than costs and someone else has to subsidize it. They were

really looking for costs to be brought down.

So our suggestion in laying this out as a two-part process is just simply that we think that our deliberations will go more smoothly, and our conclusions might be more readily understood by the policy world if we make it clear which of these two issues we're focusing in on, or both, sequentially.

Now the box on the lower left that we have labeled market condition factors, these are potential clues that we have available to us as to whether the current cost base is appropriate or payments are appropriate relative to those costs. First, of course, is the recent cost growth. Of course, recent doesn't have to be a couple of years. It depends on the dynamics. We can go back five and 10 years if we want to. And the third one, pressure from private payers, both of these are getting at the appropriateness of current costs.

The second bullet there, evidence of unbundling, would suggest that payments are too high, as we said. While on the other hand, evidence of access problems, to the extent we can measure that directly, would point to payments being too low. We like to point out that it's rather hard

to detect payments being too high with access measures, but it can give you clues that payments are too low.

Then the last two as examples, the supply of providers willing to accept Medicare patients and the volume of care, these tend to work in both directions. If we saw a large drop in willing providers or in the volume of service, it might indeed be a suggestion that payments are too low relative to cost. The converse is true, too. If we saw a massive influx of new providers and a huge volume increase, might be a suggestion that the rates are really a bit too attractive.

Conspicuous in its absence from this list of market factors is the margin. We've had some considerable discussion about this in the office, but the way we're looking at this is that given that the current costs imbedded in that margin may or may not be the appropriate cost, then the margin in and of itself doesn't tell you anything about where we ought to be. It tells you where we are now. It really does not, in and of itself, answer the question of where we think we ought to be. So the margin is basically in step one of this process.

Then the factor off to the right in the lower

right box there is an entirely separate consideration. If we thought that current costs did represent efficient costs, as best as we can determine, then we have a separate decision to make: where should we set the payments relative to those costs? Should they be equal? Should they be 4 percent above? Whatever. This is basically trying to ask the question what our standard margin should be, or perhaps more appropriately, a standard range of margin.

But the efficient modifier is critically important here, because without it we could be setting ourselves up for the scenario where the standard margin becomes a floor, and any time we have large cost increases and we dip below the standard margin it's time for a pay increase. That's what we don't want to do.

I think ProPAC was implicitly saying that for eyars back in the late '80s -- this discussion went on year after year -- they observed that the inpatient margins had gone down from well above zero to well below zero. They basically concluded that this was due to an unreasonable rate of cost growth and that we were not going to respond with higher updates. So while I'm not even sure we even used the term efficient costs, this is the process that was

basically going on.

The Commission will have to decide whether it wants to weigh in on what this standard margin ought to be relative to efficient cost. Our limited contact with experts and literature search has suggested that certainly there is no right number here for an entire industry. It's a function of the risk providers take, and that's something that we could debate around the clock. It's a judgmental matter. I guess we're just suggesting that the fact that it is judgmental is not necessarily reason to shy away from it. As we were saying before, the decisions are going to get made one way or the other. The question is whether we have something to say about it.

If we can move on to the next overhead, this is the first of several related issues that will come into play. I sort of stacked the difficult ones up front here and the easier ones later so don't get discouraged if this looks difficult. This is indeed one of the difficult questions. We would suggest the matter of multi-product providers, we would suggest that perhaps the most practical way to assess payment adequacy is to look at the combination of all Medicare services that a certain type of organization

provides.

One problem with trying to do it separately by each service is that there is indeed cost shifting among services. This is certainly the case with hospitals. There have been past incentives for hospitals to load costs into outpatient, SNF, and home health, which were then cost-based payment. Probably the only way that we've ever going to get an accurate picture of payments and the associated cost is by combining them together. I doubt that we're ever going to be able to accurately measure the degree of that cost shifting, although there have been a couple of attempts to do that. So that seems to lead to the conclusion we ought to wrap it all together.

A separate problem of sorts is that the payment rates for different services an organization provides may be at vastly different levels. That seems to be generally the case with dialysis centers. I think it's well known that the payment rates on the drugs used are way higher relative to cost than facility-based payments. So again, it's really only by looking at the two together that you get any kind of a picture of the revenue constraints that a dialysis center faces in providing services.

Now while this is, we think, the best approach, all factors considered, we do have to acknowledge that it makes the process more difficult. If we do decide that payments are too high or too low, then you have a follow-up decision: where among these services are you going to institute some change? We may need to make adjustments in more than one service, and you have to balance that out to get back to the whole.

Next issue, also not an easy one, is factors outside of Medicare. Certainly our general operating premise is that we try to relate payments to the cost of treating Medicare patients. One could consider non-Medicare revenue streams in developing the update, and in fact we did so once, many of you will remember, two years ago in our inpatient update.

But what we more wanted to talk about today was the disproportionate share and the indirect medical education adjustments. Both of these payment components in the inpatient sector are intended to compensate for what one could call non-Medicare factors. We believe that they are the only components in the entire Medicare fee-for-service that do so. The disproportionate share basically

compensates for inadequate payment for indigent care programs and no payment from uncompensated care.

Over on the IME side, part of the IME adjustment is indeed to pay for the added costs associated teaching, but part of it goes beyond that. It basically appears to respond to low total margins resulting from uncompensated care again, and the effects of above average cost due to their teaching research missions, and the like, in the private sector.

Our premise here is that for purposes of assessing the adequacy of Medicare payments relative to the cost of treating Medicare patients, it would seem that payments that don't relate to cost of Medicare patients are basically outside the scope of the analysis.

So we are proposing that when we return in December and actually try our hand at assessing payment adequacy for hospital inpatient-outpatient services, that we base the assessment on Medicare payments and cost for all Medicare services that hospitals provide, as we talked about a moment ago, but with the payments recalculated to exclude DSH payments and the above-cost portion of the IME. We then end up with a margin that is useful for analytical purposes

but does not really represent the actual revenue stream. We've separated out the non-Medicare related payments.

The third issue is considering the distribution of payments in all of this. If we were to determine that payments are too high or too low but the problem is concentrated on some subset of providers, then an adjustment to the update that would affect all providers is probably not the right remedy.

An example of this is the expanded transfer policy that was instituted several years ago for inpatient payments. Congress very explicitly intended this payment adjustment to reduce aggregate payments. But they also intended the reductions to be targeted to a specific group of hospitals, mainly those that had benefited the most in the past from unbundling. Often though, the situation as we come into the picture is reversed. Policymakers don't set out to look at the aggregate level of payment. They set out to address a distributional issue.

But in this situation we would still think it's a good idea to consider whether the overall amount of money in the system is about right before deciding whether some distributional change should be done budget neutral or

involving new money or savings.

A current example of this, a recent example, was the increase in payments that Congress enacted for rural home health agencies. They set out to help that specific subset of home health agencies, but presumably they concluded that the overall amount of money in the system was too small and went ahead and approved new money. I guess we're mainly just saying that that latter decision should not be made lightly. It's something that we ought to look at as we're considering various distributional issues.

The fourth issue is pretty straightforward conceptually. That is that due to reporting lags, our data don't always reflect the impact of all current policies. So we don't really have current payments and current costs to deal with. We try to compensate for this by modeling the effects of new payment policies, and that seems to be the right thing to do. But we have to point out that where a policy is likely to have behavioral responses, such as is almost always the case when you institute a new PPS, the modeling is really rather difficult. In fact it's essentially impossible, and we're stuck with data that are certainly less than what we would like to be dealing with.

The next issue, this really relates back to earlier discussion of payment adequacy. That is the potential role of alternative measures of financial performance. It was suggested in our earlier discussion that perhaps a return on equity measure might be more useful than margin in this kind of assessment.

But after looking into this, first of all we're not sure that a return on equity measure is really appropriate for non-profit providers. But even more problematical than that is the fact that there's no meaningful way to make this measure specific to Medicare. The same could be said for various cash flow measures. They may inform in the process, but you can't really measure the adequacy of Medicare payments with that tool.

So the bottom line is that neither of these approaches we think replaces the need for measuring Medicare payments and cost, which generally are best expressed with a margin.

Then the last issue, that I was only going to touch on lightly today, is the issue of Medicare's non-allowable costs. In the past when Medicare generally paid on the basis of reasonable cost, I think there was a little

dispute among policymakers anywhere that we need to have some limits on the cost that Medicare would pay for. But as we approach the point where all payments are prospective, the future of this non-allowable cost concept, perhaps for today we'll just say it's something that needs to be carefully thought out.

My only point in bringing it up today is first to acknowledge that it is a relevant consideration in assessing payment adequacy. You're always trying to assess payments relative to cost, and this is a question, what are costs? But also to let everyone know that we are going to do a study in this area. Basically it's the first ever study to attempt to estimate how much difference non-allowable costs make, and to find out what the actual composition of these costs. What cost elements are we talking about that really drive the amounts of money?

This turns out to be a far more difficult analytical exercise than one might think. It's going to take us a while to do it, and the results will not be available for this year's deliberations on payment adequacy. But several months from now we hope to have some interesting information and then we'll all sit back and try to figure

out what to do with it for our future deliberations.

So that's basically the model. Questions?

DR. NEWHOUSE: First of all, Jack, I have no problem with trying to disentangle the adequacy from the update. We've talked about that before and there's even, I think, precedent for that conceptually going all the way back to the beginning of PPS, since people talked about re-basing versus updating way back when.

I had, I guess, three kinds of comments I wanted to make. One is, I don't think, with kind of one exception I'll come to at the end, that we should focus that much attention on the margin. The first reason is that basically the product can adjust here. This is not a perfectly defined product. As hospitals came under price pressure in recent years, we reduced nurse staffing. That clearly affected their margin. If they hadn't done that, they'd have had a more negative margin presumably.

Another way to say that is when you use the language, cost of an efficient provider, which I agree has a kind of hallowed usage around here, that's conditional on some product. It's efficiency at producing that product. So we've always slid by that ambiguity and never really

reached the kind of product. But we could have rates cut to a point where we would turn the hospital industry into People's Express, and I'm not sure we should want to do that. But I think this is all a way of saying that the margin doesn't really tell us anything about whether we have a desirable product that we're buying or not.

The second point is actually an extension of your multiple payer point. To the degree that the private market in a locality has price competition -- and I think that's true of probably most big cities, and therefore most hospitals since there's where most hospitals are -- if Medicare changes its rates we are likely to see an offset on the private side in the other direction. Another way to say this is, this is what we used to call cost shifting. But basically Medicare announces what it is going to pay, the hospital still has costs to cover if it doesn't cut out costs, and it goes back to private payers and say, we're going to have to charge you more this year.

Now that's says in the long run hospitals are going toward some kind of margin. But the margin is determined by then the degree of competition in the local market, not by what Medicare is paying. Indeed, in most

industries we think margins are determined by the degree of competition. If you have a monopoly, you can get a higher margin. So that's one point.

The one exception to this where I think we should pay attention is to changes in margin as we're measuring them where we think we have a story to tell. So I think that's the unbundling case. We saw hospitals length of stay falling, we saw the use of post-acute care facilities, many of which hospitals owned or operated, rising a lot, we saw margins going up. This all added up to a story to tell, and I thought that was a perfectly legitimate use of the margin. So that's really as distinguished from saying, we're regularly aiming at 5 percent. That's one set of comments.

The second comment is the view that we should look at what at other times and places you've called the most-of-Medicare margin. That is to say, we should add together all the units of the hospital, which I'm sympathetic to. The problem with it is, which you don't really get to here, is different hospitals have different mixes of services. I don't know how you propose to handle that in comparing subgroups. So if we want to compare rural hospitals -- actually we just had an illustration of that with the cancer

hospitals, and how much outpatient they had or didn't have.

The idea is if we want to compare across our groups, probably the proportion of revenue that's coming from SNF and home health and rehab, and so forth and so on, is going to vary across those groups. It surely varies between rural and major teaching.

So I'm not sure how to handle that beyond trying to control for that in some statistical fashion. I don't know if you were contemplating doing that or not. That doesn't seem to me so straightforward to do.

The third point I wanted to make is, to the degree we are going to use margins -- and as I say, in the unbundling case I thought they were quite helpful in telling a story about what was going on -- I think we need the cost report, which we're going to come to tomorrow when we talk about regulatory complexity. So somehow what's going on in this part of our report has to meet up with our regulatory complexity report.

MR. ASHBY: I'd like to comment on just a couple of those points. The first one, don't focus too much attention on margins. We absolutely agree and tried to make that point, it's not really one of the factors that one

uses. That may have been less clear in the paper that you were reading, but we in fact want --

DR. NEWHOUSE: I thought there were some even more fundamental reasons not to do it than what you had here, and we should make some of those points.

MR. ASHBY: I want to make -- sort of the second part of that statement though, and that is that I guess in trying to mull this over it does seem to me though that inevitably you do reach a point where you conclude, this is the cost base we want to pay for and you can't escape the question of whether you want the payments to be less and we're looking for subsidies from other payers, or you want to be at the same, or you want it to be X percent higher or whatever. I don't know how you escape that question. It seems like one that just has to be answered before you can get to the finish line.

DR. NEWHOUSE: I guess I would just say, I don't think it can be. If I take Jack back to his prior life when he was CEO of Mount Sinai, how I allocated the portion of his salary to Medicare and to private payers is quite arbitrary. But that's going to affect what I choose to call the Medicare margin and the private payer margin. So how

those numbers come out is really an accounting convention. The ultimate story is if those costs are going to be covered, they have to be covered somewhere. That in fact probably accounts for quite a bit of what we see in the variation when Medicare changes rates.

MR. ASHBY: It does. That will eventually be a point that we will stress in this discussion of non-allowable costs. It's really the allocation that drives the stuff.

But I guess it just seems to me we end up with a vicious circle. You can't really do it, but you can't not do it either, because let's face it, you're still studying payments in the end.

DR. NEWHOUSE: First of all, I would distinguish level of margin and changes in margin, because I think as long as you're doing it consistently at least, maybe the changes tell something.

Then second is, I think there's no escaping from -- you think there's no escaping from the margins. I think there's no escaping from looking at what you're actually buying. You have to say something about what the product is. Are the hospitals producing the care you want to

produce, or are they too starved for funds, or are they very flush and they're building great palatial buildings or what?

But as I say, because the margin -- I can reduce my margin by putting in very fancy facilities, having a lot of debt service. Medicare may or may not want to pay for that. But then to come back and say, my margin is low; give me money, that doesn't make much sense to me.

DR. ROSS: Joe, can I give a slightly different characterization here? Because you could look back historically and say that in fact a lot of decisions were based looking solely at margins, and perhaps even at the margins. Instead what we're trying to suggest is, when we're dealing in the world of financial performance, let's try and get a better measure, or at least erase some of the biases that we think are in there. For example, the inpatient-outpatient cost allocation issue.

But second is to be more explicit about recognizing the limitations of any given measure of financial performance and look to the other pieces that we have. This came up last year in the context of dialysis facilities where you could look at the margin on the PPS side of payments, or you could look at all of the payments.

Then you'd take that piece of information and put it together with the extremely rapid infusion of new providers and you could start to draw some conclusions, which the Commission did.

So it's not that we're even deluding ourselves in trying to craft the perfect margin. We're trying to get a better measure of financial performance, but also to bring in more of the other pieces that we know about.

DR. NEWHOUSE: As I said, I agree with bringing in the other pieces. The issue was how to do that and still make comparisons among hospitals that had different product mixes.

DR. REISCHAUER: Joe really touched on this. I think conceptually you're headed in the right direction. But then I ask myself, practically, what's going to come out the other end?

MR. ASHBY: Yes, we worry about that, too.

DR. REISCHAUER: I think you're right to do this on an institutional or entity basis, but as Joe points out, the hospital will have inpatient, outpatient, SNF, maybe hospice, maybe home health. Just take one hospital and if I did these calculations and I found that payments were

insufficient, how would I know which particular ones were? I have a sample of 4,000 hospitals and I do a regression of these that has these services as variables, but then I can think of 4,000 other variables that I'd have to include in that equation before I'd be comfortable with the coefficients.

DR. ROSS: Is there an alternative?

DR. REISCHAUER: No, it's just that we know where the limitations of the existing system are and we're going to do one which I think is a lot more defensible, might it not come up with answers. As I said before, go to it.

DR. WAKEFIELD: Jack, just three quick questions. I'm referring now to the document that we had a chance to take a look at in advance of the meeting. I liked the notion of your taking a long term look at non-allowable costs. I think that will be very informative at least. I thought it was kind of interesting though your casting of it in the text, and maybe it is the truth, the Commission most likely will not want to address its Medicare margins to add back non-allowables. That may well be the case. But I also thought, maybe depending on what you learn two years from now there's going to be something done with some piece of

that. So it's only a cautionary note to say, I'm not sure we want to put --

MR. ASHBY: There's a future debate on that. I guess I was mostly saying, we can't really resolve that right now, especially in advance of doing the study. But there was absolutely a future discussion about whether this concept has any future.

DR. WAKEFIELD: Right, or some part of it, might get adjusted or whatever. So I just think there was a little bit of a bias that might have been introduced in that text that I don't know if you intended.

MR. ASHBY: I will work on that because I do not intend to introduce that bias. I think it's an open question, and a little down the line the Commission may want to get involved in that as well.

DR. WAKEFIELD: I think it will be very helpful to have that kind of information later on.

The other comment that I had on this document that we received in advance was your discussion about base payment rates and looking further at varying the base rates when there are differences in broad groups of providers, when those differences in broad groups of providers would

seem to warrant differences or variation in base rate. I've got a question, and if I knew the answer I wouldn't be asking you this, so please don't interrupt it as being too off the wall.

But I was wondering if it's worth giving some thought to being really sure that the differences between those groups aren't due to characteristics that could be modifiers of a uniform base rate, rather than the establishment of separate base rates. Is that another way of looking at this?

MR. ASHBY: Yes, absolutely. In fact that's one classical way to look at PPS design, is that you always ought to spin off of one rate, and if there are the need for adjustment factors for this and that that are different among groups you do it with adjustments.

DR. WAKEFIELD: So we may have that sort of a notion entertained in here somewhere too then?

MR. ASHBY: Yes, we should probably play that out a little bit more.

DR. WAKEFIELD: Thank you.

MR. HACKBARTH: Any other comments?

I guess I'm with Bob on this. He put it far

better than I would be able to. It all makes sense to me. I don't have a Ph.D. in economics but it seems logical to me what you propose, Jack. I'm very uncertain about exactly where it leads and what it's going to feel like when we do it. When I look at the list of market condition factors, some of those are readily measurable and familiar things that we've looked at before. Others are, I think going to be much more difficult to get a grip on.

MR. ASHBY: Right. It's going to inevitably be a rather judgmental process, so we tried to make that clear. It's just inevitable.

MR. HACKBARTH: But having said that, that's certainly a problem with our current framework is that we end up talking about imponderables and making guesses at them, usually offsetting guesses.

MR. ASHBY: Yes, exactly. The way I like to look at it is, we either have a broad imponderable or we have two or three narrow imponderables, but either way you end up making educated guesses. So that the added imprecision of going down to narrow variables does not appear to be really solving the problem.

MR. HACKBARTH: So I guess hearing no other

comments, we have at least the general feeling that this is a direction that we ought to be moving, although be it with a little trepidation, at least on my part.

DR. ROSS: Think about it in conjunction with the next session.

MR. HACKBARTH: Yes. Why don't we just go ahead and move on to the next session?

MS. BURKE: One question. I was looking back through this, and tell me whether or not I just missed this or whether it's not part of the formulation. That is in looking at the adequacy of the rates as well as the updates, are you also going to examine the relationship between different service aspects of the problem? So that it's not only the question of the adequacy of the rate for hospitals, but whether or not if you look across the array of services that Medicare provides, how those payments are distributed?

MR. ASHBY: You mean like inpatient to outpatient, or outpatient to physician?

MS. BURKE: I mean whether or not as you look at the totality of what we spend, the adequacy of the individual rates, whether or not the distribution among services makes sense.

MR. ASHBY: I think we were anticipating mostly concentrating on the distribution among services provided by the single organization. Once you go across organizations it just raises another level of complexity. But it's certainly there.

MR. HACKBARTH: Let me raise one other question, and maybe it's rhetorical in nature. For all of the flaws of our current framework, there is some familiarity to it, and similar thinking has been used by other people to try to wrestle with the appropriate update. We would be going off in a somewhat different ground, maybe a better ground, but it will raise a communication challenge for us. Reading this material, it was hard for me to come to grips with, and now we're talking about going to a much larger, more diverse audience with a change in our thinking. Not necessarily a reason not to do it but --

DR. NEWHOUSE: Glenn, I didn't think it was that big a change. I thought this was kind of codifying where we had come to over the last few years.

MR. ASHBY: Right. And I can visualize a situation too where the end product is a very simple, two numbers summed to a third number, and it will be a little

easier to absorb than the framework we've had with lots of details in it previously.

MR. HACKBARTH: Your point is well taken, Joe. It may be just because you're a lot smarter than I am, but when I sit down to read this, it was a struggle for me to wrestle with it and what the implications of this might be. I didn't as quickly make the connections as you. So just something to be --

MR. ASHBY: We have struggled with it too, and we work with it every day. In fact we continued to struggle with it after we sent the paper to you and ended up making additional changes. It's not easy concepts.

MR. HACKBARTH: Let's move on to the update piece of this.

MS. RAY: This is a companion piece to Jack's analysis that we just went over. When making update recommendations, the first issue policymakers should consider then is evidence about whether the base payment rate is appropriate. As suggested in Jack's presentation, we are proposing to carry over the conclusions drawn about the appropriateness of the base payment into the update analysis. That is, MedPAC's update recommendation would

include an adjustment to the base payment rate if the Commission finds that the base payment rate is either too high or too low.

The second issue that the Commission needs to consider when making an update recommendation is the effect of factors on providers' costs in the next payment year. Specifically at issue is how the Commission should evaluate factors that change providers' cost in the next payment year. My mailing materials under Tab I propose modifying this approach that has been used by MedPAC in previous years.

Just a brief review of what the Commission and other groups have typically used in examining factors that may change providers' cost in the next payment year. The first one being the inflation for input prices. This factor estimates how much costs are expected to rise or go down in the next payment year, holding constant the quality or mix of inputs providers use to furnish care and the types of patients they treat. Typically for facility-based care like hospitals and nursing facilities and dialysis we use the marketbasket concept. In contrast, for physician care, that is partly based on the MEI.

The allowance for scientific and technological advances, the S&TA, is intended to raise base payment rates to accommodate the expected effects of new technologies in the next payment year that improve quality of care but also increase costs. Improvements in productivity reflect the expectation that in the aggregate providers should be able to reduce the quantity of inputs required to produce a unit of service while maintaining service quality.

Finally, a recent addition to the MedPAC framework would be one-time factors that adjust payments for one-time factors that affect the cost of providing services that are systematic and substantial and that will improve care for beneficiaries. Examples of such one-time factors include a one-time factor for new regulatory requirements like HIPAA, and outside effects like Y2K.

So staff are proposing that the Commission focus its analysis of changes in the cost in the next payment year around the input price measure. We propose doing so because the estimate of price inflation is probably the most important factor influencing providers' cost in the next payment year. In addition, these measures can, for most service areas, be readily projected from eyar to year.

We are explicitly proposing not to annually project the effect for the other factors that we have in the past looked at on an annual basis, including the S&TA, that affect providers' costs. These factors generally account for a smaller impact on providers' costs in the next payment year and there are some methodological issues about whether they can be reliably projected on an annual basis.

We are proposing that the Commission would consider examining the effect of these other factors like the S&TA only when sufficient evidence shows that their collective effect might be significantly affecting providers' costs.

Adopting this approach would change the relative importance of factors in MedPAC's update framework, increasing reliance on measures assessing the appropriateness of the base payment and measures of changes in input prices in the next payment year, and decreasing reliance on measures estimating changes in providers' costs ending next payment year due to scientific and technological advances, and one-time factors, and productivity improvements.

Staff look forward to the Commission discussion on

this proposal. I just wanted to point out that adopting this approach does put a lot of pressure in measuring the input price inflation as accurately as possible, and using measures that are consistent, to the extent possible, across the different service settings for which we are making recommendations. In your mailing materials we raise some of the issues, a few issues that staff need to look at in greater detail when trying to measure input price inflation.

For example, one issue that we are going to be addressing is whether the wage component of the marketbasket for inpatient hospitals, should that solely be based on wage increases experienced by hospitals? Right now this is not the case. The factor in the marketbasket measuring changes in labor cost for inpatient services is weighted roughly one-third for hospital wage increases and two-thirds based on the general economy.

There are also issues with regards to the MEI, including a productivity component. We will be coming back to you with this and other issues to consider for the December meeting. For now however, staff would like the Commission's input on whether we're on the right track with our proposal.

DR. ROSS: I wanted to be clear on something that's in one of the overheads here where we talk about considering other factors only if they will affect providers' costs in a significant way. That is not to be taken as we are ignoring those factors. Instead it should be viewed as being two things. One is, for many of them, which conveniently at the end of the day turn out to be offsetting, it means we're going to devote fewer of our resources, analytic and discussion time, to dealing with things that we eventually conclude exactly offset each other and net out to zero.

But second, to the extent there are real issues there, they get swept up in the review of payment adequacy that Jack talked about in round one of all this. So to the extent that there is, for example, a significant change that perhaps gets mixed, it gets picked up in the next round.

But I want to be clear, these are not being ignored. This is just a way of treating them, if you will, on net rather than with each individual line item and spending a lot of time digging through the pieces.

MR. DEBUSK: How will we handle this nursing shortage and hospital personnel shortage that we're going to

go into here -- that we're already into -- going forward from the standpoint of cost?

DR. ROSS: To the extent it's reflected in rising wages, that feeds directly through in the marketbasket.

MR. HACKBARTH: There are two pieces to that. One is the one just raised about, maybe we should use a different marketbasket measure for wages, from one that's 100 percent hospital-based as opposed to 30 now. But then the second piece -- and one of the features of this framework that I like is the one that Murray highlighted. Again, if we make mistakes, the re-basing step the following year includes a corrective piece, so that we make sure that they don't get magnified over time.

DR. REISCHAUER: Jack, would the assumption be that we would look at the adequacy of the base payment every year?

MR. ASHBY: We had some considerable of that. I think that would be the model, if you will. But as a practical matter, I suspect what will really happen is that this will be a major issue once, and then we'll get to where we think we are, and then it will be just sort of adjusting

from that. Kind of akin to, you do a full audit once and then you do some desk audits for a while. I think that's, as a practical matter, how it will carry out.

MR. HACKBARTH: On the specific issue that Pete has raised, the issue of whether we change the wage calculation, when will that come back? Will that be at the next meeting?

MR. ASHBY: Either at the November or December meeting; just a matter of how quickly we can get ready. But we do tend to think that it's an important issue, as Nancy said, so we'll get on it.

DR. NELSON: Since the proposal is to anchor the update around the estimate of price inflation for each provider group, how close have the estimates been to the actuals over the last decade or so? Have the estimates been -- you say the estimates are the only reliable source. We have experience. All you have to do is take your estimate and find out how close the estimators were. What has been the experience with comparison with the actuals?

MR. ASHBY: I can speak to that for the hospital marketbasket. We had a rather incredible run where HCFA overshot the mark seven years in a row. I don't mean to be

critical in saying that because forecasting is not a precise science. But this last year it most definitely --

DR. ROWE: Which means they didn't overshoot it by the same amount each year.

MR. ASHBY: No. And they were all little increments, but it added to about a three percentage point error over seven years. But this last year very definitely went the other way. This was emerging evidence of labor shortages that Pete talks about, and I don't think that the forecasters really quite caught what was going on as quickly as it did, so we were off in the other direction by 0.7 point last year.

DR. NELSON: Can I get a little more clarification? Give that to me in some sort of multiplier off the estimate. If the estimate was 3 percent and it came in 2.5 percent, that's missing it by 20 percent. How close, generally, did they come?

MR. ASHBY: I don't know that I ever put it in those terms. I guess we just count percentage points off, so I'm not sure that I know the answer to that actually.

DR. ROSS: But you have a marketbasket that averaged somewhere around 3 percent over the decade, between

3 and 4 percent?

MR. ASHBY: Yes. I guess that would be right.

DR. ROSS: So it's 3 percent cumulative on something on the order of a 30 to 45 point change?

MR. ASHBY: Of 30 percentage points of change, right. I guess that would be right.

DR. ROSS: But again, Alan, one of the issues with the approach proposed here is that in the past where the Commission has always had a little line item for correcting for marketbasket forecast error, in fact that now gets thrown in with all the possible errors one might make, including failure of Congress to enact recommendations. When you come back the year following you say, let's look at payment adequacy and ask whether the base is appropriate or not. So it still gets accounted for. It gets accounted for in a different place.

MR. HACKBARTH: Any further comments or questions?

DR. NEWHOUSE: If we decide to go to 100 percent hospital weighting on the wage index, or that's coming back?

MR. HACKBARTH: It's coming back as I understand it.

MS. RAY: That's coming back.

MR. ASHBY: Yes, we'll come back to that.

MR. SMITH: And we'll look at options other than 30 and 100.

MR. ASHBY: We can. The first question to ask is the philosophical one, is there any reason to be somewhere else than 100? That's what we need to focus on and then go from there.

DR. REISCHAUER: I wonder from a practical, political standpoint whether we can get away with not discussing the things that we don't know much about when people are concerned about. Meaning all the various little technological or markets, things that we spend a lot of time on and then we say, well, that's about the same as productivity; we'll put in zero. My guess is we're going to have to do the same thing, just to show we're cognizant of these issues that people care about.

DR. ROSS: Yes. Again, that's why I want to say, we're not ignoring these. I guess we're, to a certain extent, proposing to admit our ignorance and our inability to measure them to the nearest one-tenth of a percentage point.

DR. REISCHAUER: I'm not disagreeing with where we

are. But in a sense what you're saying is --

DR. ROSS: You're saying I shouldn't hope to get away with --

DR. REISCHAUER: -- under Tab I, so you don't even have K -- that discussion next year.

DR. ROSS: You're bursting my bubble is what you're doing. Don't hope for short sessions on the update.

DR. NEWHOUSE: Bob, the other issue is how far do you go down that path? ProPAC used to contract every year for a study of scientific and technological advance, which MedPAC did once, twice? Anyway, you can pursue this in greater or lesser detail.

MR. SMITH: Let me just test my reading on that point, Bob. It seems to me with what's being proposed here, and seems right to me, remembering the complicated session we had before we netted productivity and S&TA last spring, is that what the staff seems to be saying in lay terms is, we need a reasonably high threshold before we have the conversation. We need a higher threshold than we've had in the past. You need to make a case that something is so important that it ought to be singled out. Other than that,

our crude netting formula, that ought to be the presumption.

We ought to remember that the next time we're leaned on to take account of some particular thing. We ought to insist on a pretty high threshold. I think the staff is right.

MR. HACKBARTH: Okay, I think we've covered what we need to cover today, and we are now -- I'm not saying for the day. On this particular topic. But I was just going to marvel at the fact that we're going to get ahead of schedule here. The next item for us is payment for physician services; Kevin. Somebody ought to call Dan. We're going to have time to do the cancer hospitals.

Kevin, you have the floor.

DR. HAYES: All right. We're here to talk about the payment update for physician services. What I'd like to do is to provide you with some information on the payment update for next year, 2002, and also to talk about our plans for developing a chapter in the March report on how to address this topic for the future.

Recall that the last time we talked about the payment update for physician services was in the spring when we were working on the March report, and we were looking at

the time at an estimate from CMS which showed that the update for next year would be a minus 0.1 percent. You concluded at the time that the methods upon which that estimate was based were appropriate, were reasonable, but you warned that the update could be significantly lower than that estimate of minus 0.1 percent. And that if that were true, that that would raise concerns about the adequacy of payments for physician services, and concerns about beneficiary access to care.

As it turns out, it looks like what you were concerned about will come to pass. It appears that the update for next year will be several percentage points below the earlier estimate of minus 0.1 percent. This circumstance serves to reinforce the Commission's earlier recommendation that the method for updating payments for physician services, the sustainable growth rate system, that that method should be replaced.

So what we would like to do today is to talk about options for expanding on the earlier recommendation and addressing this issue in some detail in the March 2002 report. So what I'd like to do today is to just spend a few minutes just first briefly reviewing the sustainable growth

rate that you've seen in the past, discuss some newfound problems with the system in terms of its volatility and unpredictability. And finally, to talk about how we might address replacing this system in the March report.

So from our earlier work on this topic you know that the sustainable growth rate system is a formula. It's designed to control the overall level of spending for physician services. And that it update payments on the basis of estimated changes in input prices for services. But the update only equals that estimated change if actual spending is equal to a target.

So in other words, there is an adjustment built into this system that raises or lowers the update depending upon whether spending has been hitting the target. The target itself is a function of the change in four things: GDP, enrollment in the traditional Medicare program, input prices, and spending due to law and regulation.

In the March 2001 report, when the Commission recommended replacement of the SGR system you focused on a number of different problems with the system. Two of the most important ones were, first, that it fails to adequately account for all the relevant factors that are affecting the

cost of providing physician services. And secondly, that it exacerbates Medicare's problem of paying different amounts for the same service depending upon where it's provided. This was an issue that was talked about a little while ago in connection with the pain management study.

So when we consider the update for next year, a couple of additional problems become apparent. The first one has to do with the volatility in the updates. If we look back over the history of updates under the SGR system since its inception, we see that the system started out with an update for 1999 of 2 percent. Then we saw a couple of years of relatively large increases in payment rates under the system. In 2000 and 2001, the updates were 5.4 percent and 4.5 percent respectively.

We got our first hint of this volatility problem when we saw the preliminary estimate for 2002 from CMS which showed that update estimate of minus 0.1 percent. But the volatility problem, of course, becomes very apparent when we see an update for next year which could be a reduction as high as a range of 4 to 5 percent. So that's clearly a problem in terms of swings in these updates from increases to a relatively large decrease.

The other problem that we see here has to do with just the unpredictability of the updates. We can see that on our next slide when we look at some of the details underlying the revised estimate for next year and contrasting that with the preliminary estimate you considered in the spring.

I'll just touch on some of these issues briefly here, but we see first in the case of the change in input prices which goes into the calculations, some increase there over the preliminary estimate compared to the revised estimate, where the estimate there has gone up from 1.8 percent to 2.4 percent.

I'll talk next about the other factors item, which includes several small things. Notably here, the change of 0.3 percentage points has to do with an adjustment in the system to account for the recalibration of the relative weights in the physician fee schedule, or its relative value units. Law requires that that recalibration be budget neutral, so CMS will be required to make an offsetting adjustment here which is that 0.3 percentage points.

But the big news here has to do with the update adjustment factor in the system. This is the part of the

SGR system that adjusts the update to bring actual spending in line with the target. Here we see a big change from an adjustment of minus 1.5 percent in the spring on up now to, it could be in the neighborhood of a minus 6 percent adjustment.

There are three reasons for that change. The first two have to do with the GDP factor that's in the sustainable growth rate. First we have a revision of estimates of GDP by the Department of Commerce that occurred this summer. They have changed the GDP numbers going back several years, but for purposes of the SGR system it means that the targets are revised downward going back as far as the last three quarters of 1999. The way the system is designed, all of that change in the estimates has to be absorbed by the update for next year.

DR. ROWE: There's no limit to the change? There's no corridor?

DR. HAYES: Yes, there is a corridor. The corridor is on this update adjustment factor. The upper end is plus three, but the bottom end is minus seven. So we're approaching that --

DR. ROWE: An asymmetric corridor.

DR. HAYES: That is very true.

The other GDP related issue here has to do with the current economic slowdown that we're experiencing. It's a bit deeper than originally estimated, so that too has figured into the sustainable growth rate. Makes it lower. Makes it more likely that the target will be exceeded.

Finally, we've just seen some unexpected growth in actual spending for physician services, particularly last year in 2000. Reasons for that are unclear at this point; require further analysis. But the point is, when you put all that together you end up with an adjustment like what we see here.

I should point out, you see all these question marks on the table. That's because all of these numbers are very much subject to change. Since these calculations were made, CMS has gone about more detailed work, collected further information and so on, all on a path toward issuing an update that would be published in the Federal Register on November 1st. So it could well be that the update that they publish is a bit different from what we see here, but the main point that I want to make is that it looks like we can anticipate a reduction in payments for physician services

coming out of the SGR system of several percentage points.

So we have these problems that we see now, further problems that we see with the SGR system, which makes the Commission's recommendation that the Congress should replace the SGR system all the more relevant. The question then becomes, how should we go about advising the Congress further on a specific replacement for the SGR system?

The idea that there will be a reduction in payment rates for physician services next year certainly has the attention of people on the Hill, and they are very anxious to see us come forward with some specific recommendations on replacing the SGR system. So that's really what we need to try and do for the March report.

I thought we'd spend the next minute or so just talking about some ideas for how to proceed in that area. These ideas would follow logically from what you just discussed with respect to the adequacy of payments for services and our approach to updating payments more generally.

In the case of evaluating the current level of payments, the payment adequacy topic, a couple of points to make here. The first one is, Jack talked a lot about

financial performance. For better or worse, that's not really an issue with respect to physician services because we just don't have much in the way of cost data to look at to assess the things like margins and so forth. We don't have any cost report data to work with with respect to physician practices.

So that leaves us with the other ideas that the Commission has talked about in the past, that you touched upon briefly in the previous discussion, having to do with things like access to care. The Commission, of course, has been monitoring and analyzing access to care for a long time using data from surveys of beneficiaries, surveys of physicians. Also in the access area we have some experience with analyzing claims data to assess the extent to which beneficiaries are receiving needed services. So that's one way to try and get at this issue of payment adequacy for physician services.

Another has to do with what we have called entry and exit. This was something that was particularly important, as you recall, in connection with the outpatient dialysis recommendation, update recommendation that you made last year. In the case of physician services it would be a

matter of looking at changes in the number of physicians who are providing services for Medicare beneficiaries; other practitioners as well who are paid under the physician fee schedule.

The other idea that we need to consider for this topic just has to do with something that is escaping me at the moment but that is critically important, so if you will --

[Laughter.]

DR. HAYES: Oh, yes. It has to do with two other things. We have some experience as well looking at changes in the volume of physician services, overall and by type of service. So that too would tell us something about payment adequacy, at least with respect to specific services.

Finally, we can rekindle some old fires here and perhaps look at differences in payment rates between Medicare and the private sector. We've made some initial moves in that area. So that's some thoughts about the payment adequacy issue.

The other topic to think about just has to do with our methods for updating methods and accounting for factors affecting the cost of providing physician services. We have

a tool here which is Medicare's measure of changes in input prices for physician services. That is the so-called Medicare economic index.

The problem that we have here, and something that we need to confront in the March report has to do with the productivity adjustment that is built into this MEI. That's somewhat unique in the sense that our other measures of input prices, the hospital marketbasket index and so forth, do not have a productivity adjustment built into it. So we need to focus on that issue.

That in turn will, I think, prompt some questions about things like whether we can accurately measure changes in productivity for physician services any more than we can in other settings? The answer to that question is, probably not, but it's worth exploring in the report.

The other item having to do with a productivity adjustment just has to do with how well it measures changes in productivity, what measures are used so far in the MEI, and why they are there, why they are built into the MEI instead of being handled separately. That will require us, I think, to just delve into some of the history of the MEI and the rationale for including a productivity adjustment

there. So that would be another thing we would need to do.

So that's the first two items here, for purposes of laying out an alternative method for updating payments for physician services. That leaves us then with the other unique feature of the payment update for physician services having to do with spending control, with trying to achieve a target level of spending, and so forth. I think we'll have some obligation to talk about this issue in the report. If we are not going to have an SGR system, I think the Congress will want to know, what are the other options for achieving spending control? I think we'll want to include in the report some discussion of that.

That's all I have.

MR. HACKBARTH: Kevin, just one quick question about assessing the adequacy of payment in this context. You said one of the things we would look at is volume of service?

DR. HAYES: Yes.

MR. HACKBARTH: If the rate at which a particular procedure is done is going up, does that mean the payment rate is too high or too low?

DR. HAYES: That's a loaded question.

DR. ROSS: It's both.

DR. HAYES: That's right, it could be both. If we pull out our Bible and look at the chapter one discussions in previous March reports I think one interpretation would be that the payment might be too high. I think we would want to explore some of the underlying changes in technology that might be driving volume growth. We certainly wouldn't want to be too hasty and attribute changes in volume to the adequacy of payments.

The other possibility though I think that you're alluding to is that there might be some kind of volume offset going on, particularly in the case of services where there had been some recent reductions in payment rates, do we see an offsetting change in volume because of that? I remember a conversation with Professor Newhouse once about this where he said that -- I don't mean to speak for him but I'll try it -- which is that we wouldn't necessarily expect the volume change to occur specific to that service, but that it may be more broad scale than that.

So my first thought would be that if we saw volume growth specific to a service that the first thing to look at would be the adequacy of payments, whether that's too high.

That would be my first thought, but I don't know.

DR. ROSS: Just a couple things. Having been both at CBO and MedPAC I can tell you that it just depends where you are. When fees go up you assume -- when fees are cut, you assume that volume goes up in response and that access goes down. The policy agencies hold both of those thoughts simultaneously.

I just wanted to amplify something Kevin had said about the focus on the Hill. He and I have been actually invited to a number of meetings over the past week or so, at least until the Hill was shut down, to talk about this issue, because there's a lot of concern up there about the SGR and what to do about it. Part of the problem, unfortunately, shows up in that bullet number three. It's not that the SGR is not working. It's that it's working exactly as intended, which was that spending control was deemed paramount among the objectives, rather than matching fees to input price changes and efficient cost.

The second piece of it is that legislation was enacted two years ago in BBRA which actually required the Secretary to go back and fix any data for which there was no information, which is why have the GDP revisions coming in.

Again, at the time that was done it stemmed from an earlier error which was not actually corrected, but which is believed to have caused fees to have been too low. I don't think there was any sense at the time in 1999 when the boom was going to go on forever, that we'd ever actually be going backwards and reducing this.

But a long-winded way of saying, first of all, that this is very high on the Hill's agenda. MedPAC has said, you need to do away with this recommendation, and the question has been up to us quite clearly and quite strongly, and we should do what? We need to do that.

The second is -- and I think you had a chart in your mailing materials -- as you think about all of this it is again worthwhile to -- just again to put some context around, you have a swing. You have a 5 percent reduction possibly coming up next year. That also does come on the heels of back to back 5 percent increases in fees over the past two years, which compare at least favorably with the other sectors in Medicare, and at least on an annual average are not too distinct from what the MEI has been. So there's both pieces. It's a significant cut, but if looked at over a longer period you might interpret it slightly differently.

DR. ROWE: If you used responsible estimates of what's going to happen to the economy over the next two years -- now that by itself is -- maybe I should stop there. Is it reasonable to assume that the SGR system, because of this heavy reliance on the national economic factors, would be expected to come close to or reach the bottom end of that corridor that's there?

DR. HAYES: It's really hard to say. Certainly, if economic growth remains low that would lead to a lower target, would increase the likelihood that the adjustment would be negative. The other thing though -- and this is hard to explain but I'll give it a try.

When we see a sharp reduction in payment rates under this system it, in a sense, over-compensates in that it doesn't try to just bring spending down to the target, but it has to go below the target in order to recoup the excess spending that occurred previously. So now where are you? You're below the target. So you have to get back up to the target. So it's that kind of dynamic in the system that makes it hard to answer your question.

DR. ROWE: Just one follow-up, if I may. If we were to move today or now in this whatever epoch that

decision would be made, and if were to make a recommendation with respect to a replacement for the SGR, when would it become effective?

DR. HAYES: The recommendation would be included in the March 2002 report, and in the best of all worlds we would see congressional action on it over the summer or fall in time to effect the update for 2003.

MR. HACKBARTH: That highlights, I think, part of the dilemma that at least some people on the Hill seem to be feeling. On the one hand, they want our recommendations about the long term. On the other hand, they have a very immediate problem.

DR. ROWE: That's why I asked the question.

MR. HACKBARTH: They're trying to figure out what to do about both pieces.

DR. REISCHAUER: I guess I'm not as much an enemy of this system as the Commission is on the whole. If we're going to try to constrain the overall growth of physician expenditures -- I would argue that we shouldn't be doing just physicians as opposed to the whole ball of wax. But one could also say, we start there, maybe we should extend it elsewhere.

The real problem, it strikes me, looking at this data over the last decade is not the average result but rather the volatility around it and the existing system with floors, like it can never go below 1 percent but you then make up many years of 1 percent to compensate for the fact that you didn't do the whole adjustment in 2002 would be a reasonable approach to go. Otherwise I think we're going to end up, if we think we have to come forward with some way to restrain overall growth with two very different systems and no real justification for the growth constraining component.

DR. ROSS: I think the question that's open to you as a commission is, do you feel you have to have that spending growth control in there or do you want to make this look like the rest of Medicare?

DR. NELSON: I again have to express real concerns about the impact on access if we have a cut this year of this magnitude, or next year of this magnitude. I'd point out that while a 5 percent increase looked great, MGMA studies showed that their total operating costs last year went up 6.2 percent. So they didn't stay -- that's throughout the industry, average. You look at three years under the SGR, but I think it's important to look at the

last 10 years and note that this cut would be the fourth cut over the last 10 years.

So put it in that context, and in the context of the fact that 30 percent of family physicians aren't accepting new Medicare patients, it underscores the obligation that we have to consider among our charges, concerns about access to care and the implications that another cut, particularly of this magnitude, might have within that. Among the things that we should consider, I believe, is recommending a freeze in payments while we recommend an alternative to the SGR. That's one of the things that we could do.

With respect to the productivity factor, I was pleased that Kevin brought that up again. Here again, data that I saw show that for last year for the first time primary care physicians were working longer hours and receiving less revenue in patient care dollars because of the additional things that they have to do. That doesn't equate to an improvement in productivity. I think we should seriously challenge the assumption that that productivity factor should be included in whatever alternative to the SGR that we come up with.

DR. NEWHOUSE: I think in response to Bob's comment about spending control, I think the issue is whether that's formulaic or whether it's implicit in how we're judging updates factors, which I think it is to some degree in the rest of the program in any event.

If the Congress is really -- since I've certainly been supportive of scrapping the SGR, given our past history, if the Congress really wants to scrap it what I'm about to say is moot. If they don't scrap it however, it seems to me one way to try to address the volatility, which I agree with Bob on, would be to just average GDP growth over, say five years, and work with that. Am I not correct, Kevin, that this is just one year GDP change?

DR. HAYES: That's right, yes.

DR. NEWHOUSE: So I'd offer that as a kind of -- if you keep --

MR. HACKBARTH: You smooth it in.

DR. NEWHOUSE: You do a smoothing technique; exactly, instead of bouncing from year to year. So I'd couch that as, if they're going to keep the SGR system, if they're going to keep GDP growth in a formula, then I think that would be a better formula. But I actually don't like

the formula.

MS. BURKE: Joe, would the other thing be to narrow the margins? The other option would be, in addition to the smoothing, would be to narrow the margins. My point was that in addition to the smoothing you have the margins that are an enormous variable.

DR. NEWHOUSE: In fairness, the smoothing would only handle part of this as I read this.

MR. DEBUSK: I think there's some ultimate problems with exponential smoothing but I'm not --

Murray, let me pick up on something there, and just for clarification I want to understand when you said, it will look like the rest of Medicare. Can you expand upon that comment?

DR. ROSS: I just meant in the sense that this is currently -- physician services are the only services that we have this auto-pilot that automatically ratchets payments up and down to bring it back to a pre-determined spending target. In all other sectors of Medicare it's either prospective payment where discretion is applied each year or every couple of years to the updates, or there are still a few vestiges of cost reimbursement.

Joe, actually a couple points on the technical thing. One is on averaging and single GDPs, and why we have this seeming asymmetric -- these limits. They're actual not asymmetric. They're just symmetric about minus two.

None of those are accidental. All of those were very important to achieving a very particular stream of numbers when the system was created. And there was a reason why you might not then have wanted to use a five-year moving average of GDP because that number was larger than the particular year being used.

DR. NEWHOUSE: Of course we could have phased it in, a one-year, a two-year, a three-year.

DR. ROSS: It's hard to phase in with this system. That was the point that Kevin had made because -- for the same reason whenever there's an adjustment downward or upward, it has to overshoot because this is a cumulative system. It not only has to fix this year's mistakes but any previous mistakes.

DR. NEWHOUSE: I understand.

DR. BRAUN: I have a further concern about access, which Alan was talking about. It seems to me that in times of recession, like we have now, and also the terrorism fears

and so forth, that there's going to be a need for more medical care and that that's not the time that you expect the growth of care to go down. So I would have some real questions about basing the payment on how much services are given. There are a lot of factors that go into how many services are needed.

MR. FEEZOR: I was just going to follow up. I too have a little bit of a problem with a cut of this magnitude. Let me just put my private or quasi-private purchaser hat on. Is that any missed expectations on Medicare's side we see coming out very fast a year or so later on our side. I think that Congress certainly should be aware of that, as they should have been in the Balanced Budget Act. But the volatility, and I think either a smoothing technique or a smoothing with a more symmetrical based on zero as opposed to minus two would be at a minimum.

Then I think picking up on Bea's comment, I do think though if there's going to be some sort of control mechanism that tries to gear payments, artificially or otherwise, more in line with what the economy can support, I can tell you that that's something that we're struggling with in California. There are a lot of larger purchasers

and payers trying to sit down with some of the major health systems and say, wait a minute, it seems that our health care increase comes at precisely a time where the economy, and at least the private employer-based coverages cannot afford it. And is there a better way to try to link or calibrate those two so that in good years there's maybe a better growth opportunity to take care of health care costs, and to the extent the economy cannot sustain it, at least consider that.

So anyway, I am very, very worried about the countercyclical nature, maybe not in terms of government payment but in terms of the employment based care.

DR. BRAUN: I may be on the other side of that, Allen, because my concern is the need for more services when you begin to see depression and increased illness, and fearfulness and so forth.

MR. FEEZOR: Not on the volume. Simply on the pricing is what I'm concerned about.

DR. BRAUN: All right.

MR. SMITH: Question. If we simply tracked other private payer payments to the results under the SGR system what do we see? Is it precisely the sort of offsetting

pattern that Alan describes, or do they move more in harmony?

DR. HAYES: I don't know the answer to that question. We have hired a contractor to explore the availability of data on private sector payment rates and to give us a feasibility of whether it's possible to do that kind of work again as has been done in the past. We're just awaiting the report. But the short answer to your question is we just don't know what the relationship is.

DR. ROWE: I think our impression, David, if I may respond, is that there is this, I think what Julian has described in the past as a kind of mirror image relationship, or the reciprocity relationship. That as Medicare payments go down, the pressure on the private payers goes up and it tracks along pretty well. That's the impression.

MR. SMITH: Would that mean that the two curves -- Jack, if you simply looked at a pair of years you might find things moving in different directions, but if you looked at five or six years you'd see a similar curve?

DR. ROWE: I think Julian has some --

MS. RAPHAEL: I just wanted to know, Kevin, what

we know about participation rates of physicians in the program, and how would you go about modeling what you would expect the impact to be of this?

DR. HAYES: To answer your first question about participation rates, there's two definitions of participation in connection with the Medicare program. One has to do with just the number of physicians who are providing services for Medicare beneficiaries. The information we have on that comes from survey work that we've done. The Commission sponsored a survey of physicians most recently in 1999 and asked physicians if they were still accepting Medicare patients. The results of that survey suggested that, yes, they were; that the percentage of physicians was high. I have a feeling that's the kind of participation you're talking about.

There is another form of participation in connection with the Medicare program and that has to do with the physicians who sign an agreement at the beginning of a year to accept assignment on all claims. There again, the percentage has been quite high. It plateaued for 2001 at about 88 point-some-odd percent. It's pretty high.

DR. NELSON: If I may. But the UPIN numbers this

year went down 3.5 percent. So the number of physicians with an identifier number for Medicare has dropped.

DR. HAYES: We looked into that issue. I'm glad you brought that up because that was a potential concern. What we were told by CMS, that the count of physicians in those data was influenced a great deal by work of the carriers to purge from their records physicians who were no longer billing the program. That that's something that they sometimes do and they sometimes don't do. The thought was that --

DR. NELSON: Dead, and so forth.

DR. HAYES: Whatever it is. So that was the answer from CMS on that question.

DR. ROWE: I'm not yet dead and I would fall into this category.

DR. ROSS: The question is sort of on the table of where to go next. I would propose the following, which is that staff will continue to provide the committees with whatever technical assistance they require on this in the short run and that we make this a high priority for the March report.

The one thing I would respond to, the question

came up about the legislative cycle. I agreed with Kevin's assessment in terms of reality. As a practical matter, if someone ever wanted to push this, this Commission's decisions will be known in mid-January, were Congress to get a burning urge to do something quickly early in the spring, it could do so if it moved outside the reconciliation process. But unlikely.

DR. REISCHAUER: I was just going to raise an even more frightening possibility, that it's conceivable after November 1st, I suppose if there is a Medicare bill of some kind, that there could be something even this fall.

DR. ROSS: There could be.

DR. REISCHAUER: This goes into effect when? January 1st?

DR. ROSS: The announcement will be made November 1st or 2nd and it will take effect the first of January.

DR. ROWE: But if what you said is the case that there is a short term and a long term, they'd like a long term fix for this recurrent annoyance, but they feel that they'd like to do something now because of the pressure they're getting, are we obligated in any way to respond to the latter?

DR. ROSS: I didn't say anything about them feeling that they were going to respond. They're certainly getting pressure. What they haven't figured out is how to do this in the context of the current system, which is a tweak to the SGR has the potential to cause more problems than it solves. I think there's some concern that it's one thing to do a tweak this year, but if you don't change the underlying structure then potentially next year you're trying to recover from any even bigger boost in spending. There isn't an easy way out of it.

MR. HACKBARTH: Obviously part of the congressional reality is dealing with fiscal targets and how changes would affect the budget, and whether they've got the money. This is a pretty expensive item.

DR. REISCHAUER: We don't ask that question anymore.

MR. HACKBARTH: So the dynamics are quite complicated. This is an important issue and one that we will be revisiting regularly, working towards a recommendation to follow up on last March.

Thank you, Kevin.

Okay, we have arrived again at the public comment

period. Thank you for your patience in the audience.

MS. MCELRATH: I'm Sharon McElrath with the American Medical Association. I just would like to say, I don't think you really should be very sanguine about the access issue. The survey that was done by Project HOPE that was done in 1999 was looking at what happened in '98. That was one year after the BBA. The only one of the physician changes that has occurred over the last several years that had happened at that point was to go to a single conversion factor. You did not have any of the practice expense changes.

You are looking at some physicians that have seen over 50 percent cut over the last 10 years in what their payments are for some procedures. If you put a 5 percent cut on top of that -- and maybe it's going to be something less than that -- but I think you really do have to be concerned.

The other thing is on the participation number, the 88 percent, one of the things that happens is as you have people dropping out, the people who dropped out more frequently, or the ones who drop out first, are the people who were non-participating physicians. So as that happens,

your participating physician, the agreement actually goes up and it looks better.

As to the 3.5, probably some of that is data cleaning. But to the extent that it's people taking out numbers that aren't being used and that once were being used, it does seem to indicate that there's something going on there. We do have reports in any number of -- I mean, there are newspaper reports from Spokane, Denver, Atlanta, Austin, a lot of different places in the country now where there are reports of people having trouble getting a physician to take a Medicare patient. So I just would like to say that letting it just go ahead and take effect I don't think is a great option.

MR. LEEDY: Good afternoon. My name is Don Leedy and I am the chief operating officer for the Fox Chase Cancer Center in Philadelphia. I just thought I would like to offer some commentary on some of the points raised earlier in the meeting.

The freestanding cancer centers have existed since 1983 based on criteria established by HCFA, now CMS, fundamentally looking at institutions who have the majority of their discharges in cancer. So since 1983, Fox Chase has

been an exempt center. The 11 centers are geographically dispersed over eight states. We are not governed in any fashion by each other, and we come together from time to time to study issues that affect all of us.

Our analysis early on of the APG system, and ultimately the APC system, indicated to us that the system is flawed in how it pays for cancer care regardless of setting. I agree with Dr. Rowe that high quality cancer care is rendered in many, many institutions and all institutions are disadvantaged by this current system.

The difference with the exempt centers has to do with two fundamental points. Ninety-five to 98 percent of our business is cancer care. We have no other diseases to make some money off of to offset these losses. I believe that that is true in other areas. And because of the inpatient exemption, we also generate no margin.

When we looked at the issue, Congress was very nice and recognized the problem and extended the exemption in the form of a hold-harmless into the outpatient setting. This had the advantage of alleviating the problem, but also solved an issue that medical decisions as to where cancer care should be rendered would not be impacted by whether or

not it would be advantageous to treat somebody on an inpatient or an outpatient basis. We've tried to provide data to MedPAC staff, and we will continue to do that.

Why this issue is particularly important to us is that cancer care has shifted from an inpatient treatment setting to an outpatient treatment setting. In 1996, Fox Chase rendered about 60 percent of cancer care on an inpatient setting and 40 percent on an outpatient. That has now shifted to 40 percent, 60 percent, and is likely to continue in that. My sense of the data from the other centers is that it's quite similar. If you look at somebody like Dana Farber, they're 20 percent inpatient, 80 percent outpatient, so it's really hard to make a shift.

We believe that this hold harmless is critical to the centers. We would like to cooperate with staff and the Commission to provide you whatever information that you need.

Thank you.

MR CONNELLY: Good afternoon, members of the Commission. My name is Jerry Connelly. I'm with the American Academy of Family Physicians.

I'd like to just mention relative to the last

issue that you dealt with, the payment update for physician services, and point out that, let's just say that the estimate, the revised estimate for 2002 of negative 4.5 percent is accurate, just for the sake of discussion. If it is, then over the course of the four years in which the SGR has been in effect, the average increase of an update would be about 1.8 percent; the average increase, 1.8 percent per year. Combine that with the data that we have from the MGMA that indicates that on the average costs of running a physician's office escalate 5 to 6 percent, you're putting these practitioners in a hole of 3 or 4 percent per year for the last four years, an the aggregate.

I'd also like to address the issue of access because I think it's extremely important at this point in time. Family physicians are in the forefront of the access issue, particularly at this time when we have a shortage of vaccine, of flu vaccine, we have depression issues relative to the most recent crisis that this nation is facing. We have now the prospects of bioterrorism and people interested in and requiring antibiotics, and therefore requiring physician services.

All these issues, I think paint a very important

picture for you to take into consideration today relative to the physician and what Congress can do and what CMS can do relative to this update. Because of these and the other concerns that you've articulated -- and I know you're wrestling with this as we are -- that I would really encourage your strong consideration of issuing a recommendation to freeze, or at least not issue a change in the update for this year, along with a commitment which apparently is -- I think this group and others are far along on the trail of trying to change this and committing to change this SGR system, that those two issues be combined into a recommendation. That is that there's a freeze for 2002 and a commitment to revise the SGR formula.

Thank you.

MR. MAY: Hi, my name is Don May from the American Hospital Association. Thank you for the opportunity to comment, and thank Jack and his staff for all the good work they do. We really appreciate it.

Just two quick points. First on the payment adequacy discussion. We're encouraged by some of the additional analyses that the staff are proposing. However, we do want to reiterate, I think what Dr. Newhouse said, and

caution setting a target for the aggregate margin. There are lots of important things in looking at hospital performance, and when it comes to doing updates, setting a target margin may overwhelm some of the other important things, the other financial ratios, access to patient care, things such as that.

The second point is on the update discussion. In particular, concern about the recommendation to consider other factors only if they are expected to significantly affect providers' cost in reference to science and technological advances, productivity increases, and one-time factors. Over the last couple years we've had some very important factors that have been looked at and examined under that part of the framework. Things such as HIPAA, Y2K, new drugs and devices. All have been very important and they're not captured under the regular marketbasket discussion.

Not looking at them unless you think that it's significant becomes difficult. If you're not looking at them, how do you know if they're significant, number one? Secondly, I think that there's been -- as someone mentioned, they've been offsetting in the last couple year. Maybe part

of the reason it has been offsetting is that there hasn't been the type of quantitative analysis in measuring these impacts that maybe was done in the past, as Dr. Newhouse mentioned, when Project HOPE did these specific analyses. We might recommend doing a more quantitative approach measuring these impacts versus not looking at them more closely.

Thank you.

MR. FAY: Hi, my name is Tony Fay. I'm with Province Health Care. We manage 57 rural hospitals in 20 different states. I just wanted to make a brief point, and that is the point that the physician fee schedule is also used as the basis of payment for physical therapy, occupational therapy, and speech pathology services as well as nurse practitioner services. So therefore, the SGR concept affects the payments to those individuals and also the hospitals that employ those individuals.

Thank you.

MR. HACKBARTH: Anyone else?

Okay, thank you all. We reconvene at 9:00 a.m. tomorrow, sharp.

[Whereupon, at 4:34 p.m., the meeting was

recessed, to reconvene at 9:00 a.m., Friday, October 19, 2001.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, October 19, 2001
9:00 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA PAGE

Complexity of the Medicare program and regulatory burden (December 2001 report) -- David Glass, Marian Lowe, Anne Mutti, Helaine Fingold 243

Blood safety requirements: impact on hospital costs and payment options (December 2001 report) -- Tim Greene 300

Payment for outpatient hospital care in cancer hospitals (November 2001 report) -- Nancy Ray, Dan Zabinski, Kevin Hayes 331

Consumer coalitions in Medicare (December 2001 report) -- Susanne Seagrave, Scott Harrison 337

Draft outline for the June report: modernizing the Medicare benefit package -- Mae Thamer, Julian Pettengill 343

Public comment 362

P R O C E E D I N G S

MR. HACKBARTH: Good morning, everybody. Welcome. The first item on our agenda this morning is the complexity of the Medicare program and regulatory burden. David?

MR. GLASS: Today we'd like to get the Commission's reaction to the draft report, which is in your binder there at tab K, and see if we can get agreement on the approach in there. And also, look at the draft recommendations, if we have time.

This report stems from the Congressional tasking in the BBRA and asked us to look at the complexity of the Medicare program and the level of burden placed on providers to federal regulation. The report is due by the end of December, so that means next meeting we'll have to have a final draft and get the commissioner's input, put in changes, and prepare for December publication. So it's a fairly tight schedule.

Our approach to this was to listen to the providers and CMS and beneficiaries, collected some testimony on the panel that we didn't quite have in September, and also comments on the Federal Register notice at that time. We conducted some site visits, literature

search, that sort of thing, to try and understand what the problem was.

After doing that, we decided that we weren't going to attempt to catalogue regulations and their burden or create top 10 lists of the most annoying regulations. The reason for that is that's really already being done by every professional society. They each have their top 10 list of regulations they'd like to see changed or eliminated. The things that are well known, CMS and Congress know about them already and they may already be working on solutions. The Physician's Regulatory Issues Team, for example, in CMS is working on a lot of the regulations that are bothering providers.

So we didn't want to duplicate that. Instead, we thought it would be a good idea to go back to the source of the burden, which is really the complexity of the Medicare program, and see if something could be done at that end. I like to use a gardening analogy. If you're going to prune the tree, you can cut off the branches that stick out and poke you every time you walk down the path. That's kind of the let's get the top 10 out of the way approach.

Another approach is to look at the shape of the

tree and decide is there some major branch that could be taken out of it that would improve the health of the tree and eliminate a lot of branches and small branches and things that are bothering you. We're trying to take the latter approach.

So what do we know about complexity? Understand the sources of complexity in the Medicare program, what we decided to do was to understand which of those stem from how the program started, because there are certain odd aspects of the program that are split between Part A and Part B and the use of local contractors, that sort of thing, that were there at the very start of the program. And that can be the source of complexity now. Other sources could be increasing size and scope of the program over the years and differing goals.

So we want to understand each of those and try to understand what are the sources of complexity now and then try to sort out what we call irreducible complexity. There are certain aspects of the program that you're just going to have to have in the program. Some of that exists because of the size and scope of the program. If you have beneficiaries in all 50 states plus a couple of territories

and Puerto Rico and such, that's just going to make for a complex program in itself. You have a lot of them, and you have a lot of providers. So there's a certain amount of complexity that you're probably not going to be able to avoid, and I would call that irreducible.

You have other aspects such as beneficiary protection and fiscal prudence, I mean you'd have a very simple program and write a check to each provider at the beginning of the year, but that wouldn't be very prudent and you can't go that far.

So the idea then is to sort out the irreducible complexity, figure out what can be simplified, link complexity to burden, identify what could be simplified, and if you can do that you could then identify promising targets for simplification which would, in turn, reduce burden. So that's our general approach to complexity.

So what are some of the promising targets that we've come up with? The first is kind of the excessive layers of the administration, and within that the contractor role and levels of enforcement. What we're talking about here is the program tends to get bogged down in multiple layers of issuances, regulations, carrier manuals, provider

bulletins, all of which people eventually try to understand the program from. Each does the same thing slightly differently and that can lead to misunderstanding and inconsistencies.

That problem, that layer problem, is multiplied by having many contractors, each communicating in its own way, to the providers and beneficiaries. It becomes exponentially worse when you have multiple automated systems involved in the claims processing and other aspects of the program. The software changes made prior to final regulations, for example, may get implemented differently than would have been expected. That can lead to problems where the claims processor is using their software to deny claims or to, even worse, pay claims and then the IG comes in later and says oh, that's not the way the regulation should have been interpreted. And the provider is the one who ends up with the problem.

We said why do things this way? It's an example really of the complexity because of the way the program started. When you were paying on the basis of local uniform, customary and reasonable charges and cost audits, it may have made sense to use local insurance companies to

pay the claims, and that was also something that appealed to the legislators because that would seem to be the least threatening, the thing that providers were used to have happening, and it kind of kept the federal government out of the program.

So using many local contractors and having the Part A and Part B split all might have made sense at one point. But the question is why continue it now? It doesn't make sense if you have nationwide prospective payment systems to continue with this claims processing system that was designed for uniform, customary and reasonable charges and costs.

We consider this an example of the way the program started leading to complexity that now could be simplified. So that's what we mean by the contractor role.

We think that if you rethink the contractor role, and it particularly makes sense because there are also now nationwide chains of providers. So if you want to rethink the contractor role completely, you can probably change the division of labor between the government and contractors and perhaps between all the different forms of contractors we have now. We have carriers and fiscal intermediaries and

RHHIs and DMRGs and we have program safeguard contractors. It's not clear that you want all those divisions and boundaries.

So if you rethink that division of labor, you could probably also get rid of local medical review policy, which would be a tremendous simplification. And I think we heard some of that yesterday, people saying that it's making things very complicated for providers. We'll get to recommendations in a minute.

The other question is the levels of enforcement, as far as excessive layers of administration go. This is kind of complexity because of the changes in the program probably. The new emphasis in funding from HIPAA suddenly invented these program safeguard contractors and made a lot more money available. It also gave more money to the HHS Office of Inspector General. And now we have the OIG, the Department of Justice, program safeguard contractors, a lot of people involved in the enforcement question and this is looked upon as a tremendous burden by providers. People are extremely scared and worried by the system, sure that no matter what they do, even if they follow every rule, someone's going to tell them oh, you were wrong, that wasn't

one of the rules you were supposed to follow, and they'll be in trouble.

That seems to be really pervasive here. We think a lot of that might stem from the fact that there's so many levels of enforcement now and that there could be better coordination between them. We'll have a recommendation on that, as well.

Regulation proliferation, obviously if you're worried about having too many regulations you either have to get rid of some of the ones you have or prevent new ones from being created. We think that here the pace of changes is a large part of the problem. So many new laws are passed which then require new regulations to enforce them, it becomes very difficult for people to keep up with the changes.

We think, in this case, that -- as we'll get into in the recommendations -- that Congress could give CMS more flexibility on schedules and allow them to test regulations out. And if that could be done, that might create less need for correcting laws and regulations when the first one didn't work out quite as intended. This new payment system may be an example of that.

We also think it may be a possibility of having some kind of sunset mechanism to get rid of some of the regulations that current exist. One way of doing that is say everything that's over a certain number of years old you get rid of or you re-examine. But we think it may be better to approach it by saying as you change the program have a mechanism so that you can search out things that may no longer be needed.

Examples of this may be the adjusted community rate proposal in the M+C world, which was originally designed to adjust commercial membership cost to Medicare membership costs, but now you don't need to have commercial members anymore. So the whole logic of that seems to say well, why have that?

Cost reports are another example. If we use cost reports for payment, they probably are more complex and detailed than the cost reports we may need to do, the sort of things you were talking about yesterday for updates, and looking at whether the payment is adequate. So we tried to eliminate some regulations in that way.

And finally, technology would seem to have some real benefits. The provider interface -- and by that we

mean as the providers interact with the program what do they see? What kind of forms do they have to send in? What do they get back?

Even if you can't simplify some of the payment systems, you could conceivably greatly simplify the interface with the providers so before they were sent in a claim they would be able to tell whether it would pass the preliminary edits. Does it have all the correct information and that sort of thing.

I looked kind of at tax software. Some of us do our own income taxes and we use tax software programs. It's a very complex tax system but all you have to do is put in a certain amount of data and the software does all the work for you. It understands all of the complexity. So if we could try to simplify the interface with the providers, something like that perhaps might be possible.

Better communication, we think also, if you could use technology to improve your communication by having one website that would perhaps have the answers you wanted, and there would be one of them and everyone would get the same answer, that would probably be a tremendous benefit for the system. But that would probably require more resources for

the CMS to do any of that technology work.

I think, if you'd like to discuss now, we can do so or we can go to recommendations.

MR. HACKBARTH: Why don't you go ahead and do the recommendations.

MR. GLASS: This relates to this question of rethinking the contractor role and getting rid of some unnecessary layers in the system. You can see that the idea would be to have a standard nationwide system which, if you were inventing the program from scratch now, you would probably say well, of course, what else would you do? Why would you have 100 different systems out there if you're going to provide the same benefit to beneficiaries across the country?

So we're saying okay, move to a nationwide system. It would require that Congress allow CMS to eliminate local medical review policies and local descriptions of policies and regulations. And then you'd also allow CMS to contract as necessary to do this.

DR. NELSON: May I ask a question at this point to clarify? I presume that there could still be a role for carrier advisory committees at the local area, even though

there would be a same set of rules. There still could be a role for advisory committees in terms of interpretation or the way information is disseminated to assist in particular local circumstances and things of that sort? Or did you see that there would no longer be a need for carrier advisory committees?

MR. GLASS: No, I think you could still have them. Many carriers now cover multiple states and there are still carrier advisory committees around. So I would think that you could still have that mechanism to communicate to the system. It's just the system you'd be communicating to wouldn't be oriented on local carriers, per se.

MR. HACKBARTH: It would be helpful to me if we could get all of the recommendations out. I'm trying to see the big picture, the big framework. And then we can come back and ask detailed questions about either the framework or specific recommendations. David, why don't you move through the recommendations as quickly as you can?

MR. GLASS: We can zip through them pretty quickly then.

Recommendation two, following on recommendation one, if you could develop a nationwide system that could

then be clearly communicated to providers, we would hope it would be possible to carry out this recommendation which is that providers should not be subject to penalties for relying on official guidance from the Medicare program that is later found to be error.

This is a tremendous complaint from providers, that they can actually call up, do what they're told, and get punished anyway later. It seems ridiculous to them, and it does seem kind of ridiculous to us, as well. This would raise other issues such as what constitutes official guidance and who would be considered capable of providing it, and that sort of thing.

But if you had one standard system it would be much easier to explain to people what the rules were. And we think then you could probably follow up with this, and this would relieve I think a tremendous source of -- if not burden, at least uncertainty and apprehension from the provider community.

If you have no local contractors, then you can probably rethink the proper function of the CMS regional offices, inasmuch as they're involved with contractor supervision and management. We think there are certain

other things that might happen to the program that would make this appropriate. For instance, if you start putting Medicare people in local Social Security Administration offices and that sort of thing. You may need to rethink the role of the regional offices and figure out how they would mesh with that. So we think that the current role may well have to change and this should be rethought.

In the paper we gave you, we brought up these questions of balance, of how in regulatory systems you have choices about how you might want to do things. We think it might be appropriate to evaluate whether the Medicare program has a correct balance between up front vetting of providers. That is, are you very careful who you let in your network and review them carefully up front? Or back end rigor of claims processing enforcement.

Here we think the balance is probably too much toward the back end side now. We're going to let in everyone and then we're going to check everything everyone does every carefully.

DME is kind of an example of this. They actually started requiring that DME suppliers provide Social Security numbers and an actual address. That seems pretty

reasonable, but that was considered changing the balance to more up front vetting of providers. So we think that sort of thinking could probably be applied in other areas, as well.

Recommendation five. This is interesting, what can they do? We would call them to try to rationalize enforcement roles and activity, the idea being that providers feel that they're subject to multiple audits and investigations from all these different agencies involved. If the current structure is appropriate, it would be nice to be able to explain to people why and how it's beneficial. And if not, we think it probably should be rethought and perhaps rationalized in some way.

We think that also might lend itself to making better use of audit and investigation results, so you don't have to have multiple audits and that sort of thing.

This recommendation speaks to trying to slow the pace of adding additional regulations. We're trying to do that by avoiding corrective actions, where Congress passes a law, it's put into regulation, things start happening, they don't like the result and have to pass another law to correct it. We think that some of that could be avoided

with more reasonable timelines on setting up, for example, new prospective payment system and providing more resources for CMS to develop and test the regulations thoroughly before implementation.

We'd also, of course, like the people who are doing the testing to be independent of those perhaps proposing the system, to make sure it's a good test. Again, the idea here is we're trying to prevent the constant phenomenon of a law being passed, people not liking the result when it finally happens, and then having additional series of laws and regulations.

This is at the other end of the regulation life cycle, where we'd like to be able to eliminate regulations that become obsolete as a result of program changes. Again here, the adjusted community rate proposals in the M+C world and some of the perhaps the cost reports on the fee-for-service side are examples of this.

This is kind of our catch-all technology recommendation, that CMS has probably dropped many years behind the power curve on this. Again, tied to the first recommendation, in that if you simplified the system and have a standard system, this becomes much more a practical

thing to do.

Right now you can go into a gas station and flick your card through the thing and it communicates by satellite, approves your card by the time you put the gas nozzle into your tank. But for a provider to determine whether a beneficiary is really covered by Medicare they have to consult the common working file, which doesn't work 24 hours a day, isn't available necessarily all the time, and is three or four weeks behind. It doesn't seem possible that that has to be that way.

So we think if we simplified the program to begin with, go to a standard system, that would allow technology to be used in a much more appropriate and up-to-date manner and relieve a lot of the burden providers feel.

That's what we've got.

MR. HACKBARTH: Thanks, David. Just a word about the draft recommendations, in particular for the people in the audience. This is the first time that the commissioners have seen these, and the purposes of the draft recommendations at this point is to stimulate thinking and discussion. So what we finally agree on may or may not have any similarity to these draft recommendations.

MS. NEWPORT: David, first a context question. The so-called RACER bill was just passed or it will be passed by the House fairly soon, which is an attempt to get at some of the issues with the fiscal intermediary structure. Yesterday Bob Berenson spoke to us about he thought that would make it even more complex.

I guess in the context of this discussion and this chapter, I think we need to be aware of that and try to frame the context around what that may or may not do, although I have to confess I haven't read it in detail.

MR. GLASS: Yes, we've been trying to follow some of the legislation. First there was something called the MEFRA, Medicare Enforcement Fairness Regulation Act or something like that. That was around. Then the Ways and Means Committee had theirs, which was -- did it have a name, or just 2786? They had their version of a regulatory burden bill.

MS. NEWPORT: I guess it would be helpful --

MR. GLASS: And then Commerce has now become the RACER bill. A lot of those tend to deal with the appeals process and some -- at one point there was things about could they use extrapolation to go from a sample of 30

claims to a universe of claims. We know that those things are around, and that's why we're trying to go to some of the root causes of complexity, rather than to address each of those things they happen.

MS. NEWPORT: Contextually, I'll go and revisit it now myself. But the other issue, and I hope that we can put it in the text, in alignment with this first recommendation, is that on the policy interpretation side, for health plans, when we have people go for urgent out-of-area care or to a non-participating provider, we do pay them on a fee-for-service basis, emergency care as well. It is very, very difficult for health plans to pierce the interpretation network, if you will, for the fiscal intermediaries and others that determine payment and policy and make coverage decisions.

It's been something that CMS has been somewhat reluctant, because it's in another part of the house if you will, allow us access to. So it's very difficult to get this, and there's extreme variability across the country in some areas. Sometimes it's very consistent.

So if nothing else, in reference in the text, talk about the plans that other payers have. And the line is

you're not a provider. Well, indeed we are a provider in some context. So I think that would be helpful to acknowledge that we can only pay properly if we have access to the data that way.

MR. HACKBARTH: Jack, before you take it, it would be helpful if we could have for the commissioners very brief summaries, if you will, of some of the major ideas in the bills on the Hill. I'm not talking about all of the gory detail. I'm just looking for something that will help stimulate our thinking about what the possibilities are. So brief and high level.

MR. GLASS: We can send you that by e-mail.

MR. HACKBARTH: Janet was just asking whether we're going through draft recommendation by draft recommendation. I don't think that's necessary at this point, because it's not like we're trying to prepare for a vote on any one of these recommendations. Again, we're trying to get the major ideas.

DR. ROWE: David, I found this material, clear, well presented. I have a couple of general comments, some of which may expose my lack of familiarity with CMS.

First of all, I do think it's helpful up front to

identify that the problem, however you want to state it, has several elements, one of which is regulatory, one of which is the complexity of the system, but one of which is cultural, structural, et cetera in the organization that we're seeking to modify. There are some inefficiencies. Some of it is related to less advanced technology and inadequate capital investment, but there are some other inefficiencies and retention of archaic activities. Something that shows these different things.

If I were faced with trying to fix this organization, I would do two things. It may not work and it may not be the right approach. The first is I would wonder why there isn't more discussion about one of the most effective levers that you have in making these changes, and that's money. What is the relationship between the CMS budget and the problem.

There are a lot of people, some here, who write articles saying that CMS is chronically underfunded. If I were a congressman and I thought there was too much of it and it wasn't efficient and there were too many layers of administration and too many regional offices and too many people, the last thing I would want to do is feed it more so

it could grow more levels of complexity. And I might say let's feed it less and see what happens.

If you, in fact, yoked feeding it less with you guys give us a list of the things you want to get rid of and we'll get rid of them for you, but you can keep the money. That is, nobody's going to give you a list of things to get rid of if, when you get rid of them you take the money away that supported those activities, or you take all of it away. There might be some "profit share."

Some discussion about the relationship of the budget to the problem, because it's not clear whether we need to feed it more so it can be more efficient and re-engineered or feed it less so it doesn't grow more complexity and layers upon layers.

MR. HACKBARTH: Jack, Murray just said you're proposing prospective payment for CMS.

DR. ROWE: I just think the documents we create should at least have a paragraph on this. Like one commissioner had the absurd idea that maybe -- but that was laughed off the court.

The second thing that I would do, after I wondered about the relationship of the funding to the problem and the

fix, is I would say who should I get to help me with this?

I don't know everybody in this room, but I don't think the person to help us with this is in this room. With all due respect to your background, there are people who do this for a living. There are people who have doctoral degrees in organizational development, re-engineering. This is not the first kind of problem like this. And what expertise does MedPAC have with respect to these kinds of mega issues?

So then what we wind up with is a list of draft recommendations which are kind of ad hoc on here's an idea, everybody thought this was a stupid thing, let's get rid of that. And maybe we have too many regional offices. But my guess would be that if we did all of these things it wouldn't fix the problem.

So I just wonder whether or not somebody else should do it. I know we're not supposed to make recommendations like that, either, but...

MR. HACKBARTH: Our recommendation is, take this back.

DR. ROWE: You sent this to the wrong office. So anyway, those are my thoughts. Thank you.

MR. HACKBARTH: Could I just react to Jack's point? Two reactions, on the last point about other people having more expertise, I certainly think that's true in some aspects of the problem. I really don't think the charge to us, though, was to redesign CMS or do a reorganization where clearly we did not have the expertise.

I think they are looking to us, though, to point in some general directions.

DR. ROWE: One of which could be to hire an outside organization.

MR. HACKBARTH: One key issue you put your finger on at the front end of your comment is the link between flexibility and efficiency, which is what we've been saying to providers for a long time. The problem we have right now, as I see it, is that we've got no flexibility, lots of very specific commandments in terms of how things are done, and then an expectation of efficiency. And you can't have that combination.

It's sort of a basic point and it doesn't take a genius to figure out, but apparently it needs to be emphasized. I think we can make a contribution there, just pounding on the nail some more.

MR. DEBUSK: Jack, maybe we have too many of those kinds of people you're talking about stirring the pot in the present situation.

One of the overlying things that's a major problem, as you all know, we just do not have the information systems to give us the information, even as a commission, to do the things we need to do. Now that's overlying everything.

Underneath, though, I agree with your statement. CMS should move to a standard nationwide system of claims processing. I agree with that 100 percent.

But one of the other things we need to do is certainly reduce the number of fiscal intermediaries that we have. I think we should reduce that to six or 10 or something like that, because right now it's very inadequate. You have a few that do an outstanding job. I think we should look at those people who are doing an outstanding job and see if we can drive the reduction in their direction.

The other thing, last year we rolled out all these prospective payment systems mandated by Congress. We rolled it out there, there was no dollars given to CMS to train the fiscal intermediary, certainly no dollars to train the

provider. So what did you get? Total confusion, absolutely we just missed the boat.

When we roll out these programs, we need to fund the educational piece of these programs. That is really missing in the present system, in my estimation.

Another thing we need to do is reduce the number of levels to interpret policy. By the time it gets to the provider, how do they know what to do? You pass through two or three or four levels of decisionmaking at the various levels. Some of those levels need to be wiped out so we've got a more straight access to what the real rules and regulations are.

DR. WAKEFIELD: I actually like this set of recommendations that you put forward. By anyone's definition, this will not be a panacea and address all problems under all circumstances. But I think in general what you put forward is a good place to start. Even by virtue of raising some of these issues -- like in the second recommendation, gee if you pay attention to the guidance that you get from people who represent Medicare, you still are subject to civil penalties if there's an inconsistency between what you were told and what the law really is.

I think, in some respects, these recommendations, by stating them are going to illuminate how ridiculous some of the stuff is. That's a good example. Because it's likely that while the providers may be aware of this, not all policymakers are. And so even naming some of these problems, I think, is a positive thing.

So that's just a general reaction. I'm sure there could be a different set, or maybe a more comprehensive set, but I just think in general, for different reasons, it's a good point of departure.

Two comments, specific comments. One on the first recommendation, David. Would you tell me, it seems to me in the abstract this makes perfect sense, a standard nationwide claims processing system. But in my interest in not overlooking anything, was there any significant feedback that you can recall from any of the groups or individuals, providers or others, that you might have spoken with that would have raised any flags about that that didn't come through in the text? Anything in particular? Or was it pretty much consensus on that one? Because as I said, I think in the abstract it makes sense. I want to make sure I'm not overlooking anything.

And then secondly, and my last comment, on the recommendation that talks about CMS testing regulations before putting them into effect, that's another no-brainer, one would think at some level. But I guess I'd ask is there a reason to put, at least in the accompanying text of this, that we should include that when those regulations are tested, they should include a focus on any group that might experience a differential impact?

So for example, maybe it's a broad regulation but it may impact academic health centers, or have the potential to in a slightly different way, whatever the new regulation is. Or it might impact small rural hospitals under certain circumstances in a particular way.

So could they put a little bit of a filter on it when they think about that testing that would allow us to look at any kind of differential impact, at least in a broad sense, higher compliance costs or whatever for a particular subcategory? If that could be added in the text, that might be useful.

MR. GLASS: We can certainly put that in the text.

DR. WAKEFIELD: That's all I have, and if you'll comment on the first.

MR. GLASS: The first one, I think the most controversial part of this might be the local Medicare review policy, getting rid of local Medicare review policy may be the most controversial thing. Because some people feel that -- well, I'm not sure what they feel. They either feel that there really are local circumstances that make people there or maybe the facilities there different, and therefore different things should be covered.

I don't follow the logic of it really, but there certainly is a group of people who feel that that's very important and if they can get a device approved perhaps in one place and in one region, then that will be a better argument for getting it approved in others.

I don't quite follow the logic because if you have evidence-based medicine and you know that something is a good idea, then I think it would be a good idea nationally. In the absence of that, I don't understand how you know it's a good idea.

I would say that's probably the most controversial thing.

DR. NEWHOUSE: Two general reactions. One is, I thought we should attempt to frame some recommendations that

would be directed at simplifying life for beneficiaries. All of our recommendations here are directed to providers. And while they all seem reasonable, at least at first blush, to me, we have quite in the draft text that talks about beneficiaries but then nothing in the recommendations.

I was talking about this with Glenn beforehand, who recalled for me the Barbara Cooper-Bruce Vladek document that we've been sent that we both think has some potential leads for recommendations.

The second general reaction on the recommendations that talk about the nationwide system both for standards and for enforcement, several recommendations. I wondered if it would be useful to reflect what has been learned with respect to the IRS. The IRS also has a very complex set of regs to enforce. I know the literature, they don't get enforced uniformly across the country. Even though the system that is here might, in some respects, you're trying to move it toward where the IRS is.

There's also, I think, some enforcement differences and potential multiple -- I don't know enough about the IRS to go much further down that road, but it struck me that you might take a look at what lessons, either

positive or negative, the experience with the IRS has to offer here.

MR. GLASS: I don't know how popular we'd be if we said we want to be more like the IRS.

DR. NEWHOUSE: No, but all the more reason to -- in ways of being realistic about what this will accomplish. I mean, I think these suggestions, as I say, make sense to me but they won't be a panacea.

MR. GLASS: No, they won't. And the IRS has the same problem of whether if you get guidance from someone over the telephone --

DR. NEWHOUSE: So how do they deal with this then?

MR. GLASS: There are some certainly similar things.

DR. REISCHAUER: I know a little more, but not probably enough to be quoted outside of this room. When you get an answer on the telephone, it can drive your behavior but it's worth nothing beyond that. The IRS issues letter rulings when you send in and ask a question. The letter ruling officially only applies to your situation but, in fact the tax courts use it as precedent and then there are special tax courts and findings in them.

So I think it really is a level of treatment of these issues that is fundamentally different from the way Medicare is.

DR. ROWE: But in the area of health care there are also precedents. I believe a law was recently passed in Texas, but I don't think it was signed by the government, that had a provision in it that if you were a provider and you were on the phone with a health plan representative and you said I'm going to do an operation on Mrs. O'Brien for such and such, and the health plan representative said fine, that's approved over the phone.

And on January 31st Mrs. O'Brien stopped being a member of your health plan because her employer switched and the operation was done on March 1st, the health plan still had to pay, even though that person wasn't even a member anymore. Because there had been an indication verbally that the health plan would pay. That's a law somewhere in the United States of America, I believe.

So with respect to -- forgetting the IRS, you can go to other elements of the health care enterprise and see examples of relationships between providers and the payer which might inform your decisions with respect to this.

Alan may know more about this. I don't know if this is accurate from your point of view, Alan.

DR. ROSS: Just a couple of points to react to Joe. I guess, first of all, it's telling that the Joint Committee on Taxation put out a 1,500 page three volume document on simplification in the tax world, so it's not easy.

But on your point about doing something with respect to beneficiaries, I guess a couple of things. One, we actually made a number of efforts to reach out and find some of the issues there. Whether it reflects the fact that there's not a lot of money attached on that side, we did not get an overwhelming amount of feedback from people.

One of the pieces of low-hanging fruit that we did find was on Medicare secondary payer provisions, which had people filling out a form with every encounter. That's actually already being addressed.

The other, I think, major source of complexity from the beneficiary perspective is inside the benefit package and I think perhaps a good place to deal with that is in the June report that we'll be talking about later this morning.

DR. NEWHOUSE: Then I think we should point toward that. I would have said also a source of complexity in the program is the probably lack of a stop-loss provision in both Parts A and B that drives people into supplementary insurance, which creates all kinds of interface issues.

MS. RAPHAEL: But I think that's reflective of the past, that the beneficiary side is not organized in a way that they can make known some of the issues.

DR. ROSS: But even in our attempts to work with organized beneficiaries we did not get a lot of input.

DR. NEWHOUSE: But there is stuff in the text that points toward recommendations. They just didn't seem to surface in chapter five.

DR. ROSS: Do you want them to?

DR. WAKEFIELD: Could I comment on this point? David, it was really helpful to me that you included the text from the legislative language for this particular study on the front end of this document. Then there's no confusion about what it is Congress is asking us to look at.

Just on Joe's point, it's asking us to look at providers. If this is all there was on this study, it really seems to be very provider focused. I'm sure that

doesn't negate adding some beneficiary-related recommendations, but it seems -- at least my reading on this, it's impact on providers.

MR. FEEZOR: Joe had exactly what I was observing and I, too, had picked up that, in fact, Congress had asked for it from the provider perspective.

I'd just like to note it might be worth reflecting that I think the fact that Congress views the program in sort of a constituency silo mindset may, in fact, contribute to some of the complexity. And I think to really look at the kind of overall simplification and improvement that Jack was talking about -- and I do think politically there may be some opportunities to look at it in a much larger perspective -- I think backing out of that specific constituency impact group mindset on a broader perspective -- and I do think, Glenn, your comments about the forthcoming June report may provide an opportunity.

So it may be helpful, I would think, in the context of saying this simplification effort, or it may be very helpful to be undertaken after or subsequent to a revisiting of the program is going to be redesigned at some point, in terms of its benefit structure. Because I think

that would change the game rather substantially.

MR. HACKBARTH: Just for the record, the mandate does refer to patients as well as providers. The summary--

DR. ROSS: The next page, the top. The top of three.

MR. HACKBARTH: The actual statutory language is there. What I'd like to do is go

back to our queue. We've got a bunch of people who have been patiently waiting here and I want to get to them.

MR. SMITH: Let me try to be brief. David, I found this very helpful and learned a lot from reading it.

A couple of observations. Actually, Jack provoked the first one. I think it's important to remember that the complexity of this system shouldn't be analogized to sedimentary rock. It didn't just accrete over time. It has very deep constituency roots.

The complexity here has a political dimension and Allen just referred to it, in part. But I think as we think about what it is sensible to recommend, and I mean sensible in an efficiency sense, we need to be mindful of the political context in which the complexity arose and some of

the reasons that it is unlikely to go away.

In that context, I think we should try to distinguish between where we can reduce complexity with technology and better information systems and better processing where the political obstacles will not be as serious, and where we think we want to try to reduce complexity by going after someone who, in turn, has political weight and political muscle.

I think there's an important difference. I thought the weight of the recommendations didn't focus enough on some of the technological and information system opportunities where I think the resistance will be less.

Second, I was struck and I think a little troubled by the discussion on front end rigor, back end rigor, again in part for political reasons. Back end rigor comes because that is always low-hanging fruit for politicians. Fraud and abuse, a corrupt provider. It doesn't make any difference whether it's .1 of 1 percent of all providers, it's an irresistible target and no sensible bureaucrat is going to set themselves up for that kind of attack at the back end.

Unless we had a profound, and extremely unlikely, change in the political culture, I don't think we can expect

bureaucrats to reduce their back end rigor and make themselves low-hanging fruit on the fraud and abuse.

I wish you were right, that this tradeoff were possible, but I really don't think it is. The tolerance of the bureaucratic apparatus for the political attacks that come at the back end is very low and it's hard to imagine it could be otherwise.

I think some of the same political constraints apply to the flexibility issue but I think that's more promising.

Lastly, Jack, on your do you feed the beast or starve the beast, I think it's the wrong question. If you don't change what the beast has to do and you give it more money, you get more of what you don't want. But money is not the problem. The problem is what you're telling the apparatus it has to do.

I think to think about it is could you fix it by starving it? The answer is probably no. You would just do everything that you now do badly even more badly because you had fewer resources.

DR. ROWE: I think, if I could respond, I accept that, David, but I'm not ready to reject the notion that

linking some of the changes that we want the organization to do with financial incentives, one way or the other, so that could in fact benefit from improving its efficiency, by having more internal resources to use for other things, or something like that might not facilitate some of these behaviors.

These are, after all, even though they're CMS, they're still human beings. And they do respond to the same incentives that everybody else does. In fact, maybe moreso because they've never been exposed to these incentives. That's really what I mean.

MR. SMITH: Fair enough. But I think that is a different question than the one you initially posed which is, does it make sense to try to make it harder for the apparatus to introduce complexity by giving the apparatus less money? I think that's the wrong question. The complexity is introduced by and large externally, unless money simply makes it even more clotted and clogged up.

MR. MULLER: My comments follow somewhat on David's. I think a lot of the complexity is, in fact, introduced by the pace of all the changes that are introduced. For better or for worse, providers figure out

with rules that are 10 or 20 years old, how to live with them and adjust them and so forth. And when many come along, they may not like those rules but they figure out how to deal with them.

It strikes me that the pace of change is not going to slow down at all because Medicare is just inherently a political process. Some of the stakeholders wants things changed and those things will continue to change.

From both the point of view of CMS and from providers, in some ways however, the regulations, the laws that come forth are seen seemingly as cost-free to them. The CMS budget, as various people pointed out, doesn't get increased when BBA comes along and so forth. A number of the administrators wrote last year in Health Affairs about underfunding. That's been discussed here.

And providers really also don't have their budgets increased when these various rules come along.

So one of the suggestions I would make that we consider is that as new legislation is passed that both CMS and affected people, whether that be providers or intermediaries -- and it's not clear to me how one relates this to beneficiaries -- somehow get some adjustment as a

result of this, or a CMS budget or a provider budget gets adjusted to take into account. Otherwise the rules that come along, in a sense, are seen as cost-free and obviously it brings the administrative budget of providers to what I understand to be the highest of the G-7 countries in the health program as a percentage.

Obviously we have a lot of data indicating that the CMS budget is defined as one of the lowest vis-a-vis the expenditures on the health plan.

But I would like to ask the staff whether the right form for this is to consider some kind of recommendation that the costs of regulations be put into the CMS budget and into Medicare's cost basis in some kind of appropriate way. Because otherwise these rules are just going to keep coming forth. And I do think that a lot of complexity, in fact, comes from the constant changing of this.

Understanding, at the same time, that there's a reason for this changing, as David and other people have articulated. People want to change the program because the stakeholders want to see changes. I don't think that's going away. I think we need to have some accommodation,

however, for what kind of havoc that wreaks in the system when these things are changed constantly.

DR. LOOP: I don't think this commission has the ability to debride all these regulations, but we do have one resource and that's common sense, which I think are applied in these recommendations.

There's one worry that I have, and that's the consolidation of some of these fiscal intermediaries or other contractors. I'm not sure we wouldn't be just creating fewer and larger bureaucracies. I think that we have to have uniform and simplified standards and, as many discussants mentioned, fewer decisionmaking layers. Otherwise we're creating very large bureaucracies again.

MR. GLASS: We left open what would the efficient division of labor be and how many contractors of what sorts you'd want. We don't say how to do that. We just want to get rid of the layers of decisionmaking in there, and the fact that if you have different systems and different rules in different places it complicates the system. I'm not sure we'd be creating --

DR. LOOP: As long as we simplified the new standards that apply to those new contractors.

DR. NELSON: David, I really liked the way that you approached this. I agree with the recommendations. While some of them are structural, a number of them are process. I'm comfortable that those that fall within the structural context are prudent and reasonable and it doesn't bother me that we aren't experts in organizational design.

I also subscribe to your approach to look at the overall tree, but there might be a couple of branches that are worth pruning just because they're so pervasive in causing problems and hassle. I think that it would be well worth referencing the documentation requirements as a major source of confusion and disgruntlement.

If you do that, it seems to me that it would be perfectly appropriate among those process recommendations that you have to make a recommendation that the Secretary would conduct a demonstration of evaluation of management requirements based on encounter time, or something of that sort, at least to put on the record that we considered some concrete specific steps to deal with one of the biggest problems, which is documentation and coding complexity confusion.

The need for applying diagnosis codes to all

laboratory tests drive people nuts. The way carriers deal with that is so uneven and confusing that it just -- and that's such a big problem that I think we can deal with this in the general context as you do. But we can still identify a couple of very specific areas that are such a big source of consternation.

The second example that I think you should consider referencing, and perhaps have a recommendation, deals with the difficulty that we encounter with extrapolation from a small sample to a large universe. That drives people crazy. A person makes a simple coding area and all of a sudden they get a payback bill for hundreds of thousands of dollars in some instances.

Perhaps one of our recommendations could be to consider restriction on extrapolation if it's the first time that the error is caught. It doesn't seem to me that that is getting too specific. It seems to me that people who read our report are going to fault us if we don't include some things that everyone agrees is causing so much problem out there.

So I'd suggest considering that.

MR. GLASS: We thought about how to look at some

of these specific ones which are well known. I think you can add to that list the Medicare secondary payer question and the ABN, advance beneficiary notice. On site visits, these things just kept coming up. The E&M documentation is another biggie. These things kept coming up.

I think in some cases we used them as examples, but we refrained from having a section on each of those because a lot of these things are already being addressed either in CMS or in Congress. We didn't think we had much to add to that. But do you want to mention them? I don't know.

DR. NELSON: Why don't you humor me and include them, and when we consider our recommendations if you all want to argue to delete them, it's okay with me.

MR. HACKBARTH: To me the approach of having the recommendations broader gauge, but then when there are some particularly poignant examples of problems having them mentioned in the text is a good approach. Do you feel comfortable with that, Alan? It sounded to me like your request was that, for some of the most flagrant examples, let's make sure that they're mentioned in the text as opposed to recommendations to the Secretary to use a

different statistical approach.

DR. NELSON: I think the important thing is to have it mentioned in the text. But it may be that acknowledging in the text the problem logically leads to a relatively simple next step, which is to investigation some way to handle it. I don't want to burden this with a whole bunch of those kinds of things, but if there are a couple that everybody agrees is a major heartburn or headache cause, we ought not to miss the opportunity to make a recommendation to do something about it.

DR. ROSS: Can I just interject one logistical issue for us on this? A lot of these things are being dealt with in legislation that is currently moving, may or may not make it out of the committee or through one chamber by the next time the commission meets. It's probably better if we're not making recommendations that by the time this hits the streets have already been enacted and put into law. Whereas, if we illustrate I think specific issues, we can use fairly strong words to describe them, but keep them under the rubric of the general problem and then the specific application of it.

That may address what you want but without putting

us in a position of having recommended something that's already been fixed before we even get the report out.

DR. ROWE: I see the problem is that we all have our favorite list of annoying, incredible policies that CMS has, as well as Aetna has and every other large organization. I see, however, like this example that Alan suggests, this is a policy. CMS could be the most efficient non-regulated organized entity in the world and it might still have a policy that if they catch this kind of an error they extrapolate to that provider's entire patient population and send the guy a bill. It's unrelated to regulatory burden, it's unrelated to complexity. It's a policy of how to deal with this kind of activity.

So I see it as a different kind of thing than this chapter is supposed to deal with. It's a fairness kind of issue.

So we don't want to have too many different kinds of things on our list of favorite things we want to fix because the risk is that they'll fix all these favorite things but not change the entire system, which is really I think the overall question.

I'm not against including some of these things but

we should candle each of them up to say is this really a regulatory complexity problem.

MR. HACKBARTH: Let me just do a process check here for a second. It's almost 10:10, so we're already over time on this. I think this is a very important topic and, in addition to that, we don't have a whole lot of time left on it. We certainly don't have a lot of meeting time left to get this work done.

So I do want to go for another 10 minutes or so, but one thing that we need to do before we wrap this up is I'd like to go back through the individual recommendations that David presented. Not your discussion, but I just want people to say raise your hand if a particular recommendation proposes a serious problem for you and you would strenuously object to it.

You will have another cut at this later on, so if you don't object that is not tantamount to a yet vote. But we're just trying to provide some direction for the staff in a very short period of time. So I've got two people left on the list to comment, Carol, who's not had any chance yet; and then Joe. But please let's keep it brief so we can get our work done. Thank you.

MS. RAPHAEL: I thought that you did a very good job in terms of organizing the material and I really appreciated the fact that we didn't focus on 30,000 pages of regulations but try to look at the sources of complexity and what we can do. I do like the way David posited it, which is where can we get something done rather than run into a lot of political barriers.

I think that you've addressed the issue of how do we alleviate the multiple layers and try to achieve some standardization. I think you need to emphasize more that in the federal system the notion of having some kind of local input really is not relevant in the way this program is structured because there is value to having local input and involvement, but we never got that in this program because all of these regional groups or carriers really are not locally-based and don't give you whatever is you value in the system that involves people at the local level.

I think in whatever you create, I think we have to be mindful of the fact that Medicare is the purchasing organization and enforcement regulatory organization. As a purchasing organization it has to decide what it will pay for, what it will pay, and then how to make sure that it

gets what it pays for. I think that's Medicare's obligation as a central entity. Whoever this group of entities are that end up being the contractors should be responsible for paying, not for making those kind of critical decisions that I think have to be made by the central body.

I also think you dealt with the issue of how do you increase certainty and predictability in a program now that has had a very high quotient of unpredictability.

What I still feel is somehow missing is the hard part of this, which is how do you deal with the fact that we have rapid change? We have to find some new mechanisms to make more rapid decisionmaking while you still adhere to a political process that has to give voice to many constituencies?

I think that is a really critical issue for this organization. How do we garner more political support for this particular organization and reduce expectations? I don't know what a recommendation might be in that realm, but I feel it's an important realm.

I was thinking of other organizations, the way Joe was of the IRS. There is an organization in New York that is in charge of foster children and child abuse. It's the

most abused organization I've ever seen in the public sector because it was in the newspaper every week because it was impossible not to have some instance of child abuse or neglect, and it was always the poster child for a completely ineffective organization.

That has been completely turned around and that organization has become the most effective. You know the innovations in government awards, it gets the award for being innovative. There's just less expectation, more of an understanding, that this entity cannot root out and prevent every instance of child abuse and neglect or every bad thing that happens. There's just much more of a sense of support from the political process, as well as from the citizenry.

I think that is an issue that somehow you need to tackle in our recommendations because I think this will be important in the decades ahead.

DR. NEWHOUSE: I know we're trying to stay at the 30,000-foot level, but there is a technical fix for Alan's extrapolation problem that if we're going to mention it in the text we should mention it. Basically the statistics of say predicting a baseball player's final batting average when you only observe the average after 10 at bats is not

the average after 10 at bats. It's some weighted average of the average after 10 at bats and everybody's average. And the weight on the number of at bats keeps going up as the number of at bats get higher.

That's all well developed in statistics. So the notion of extrapolating from a very small sample can be dealt with.

The other thing, Alan also mentioned linking diagnosis and the text. The only thing that concerns me, we need to make sure we're not tripping over ourselves when we get to process measures of quality and quality measurement on that front.

DR. NELSON: No, I wasn't calling to eliminate that. I was saying it's very confusing the way it's currently required.

MR. HACKBARTH: David, would you walk us through one by one? Again, what I want from people here is a show of hands. Raise your hand if this one causes you significant problem. If in fact there is one that causes you significant problem, rather than have a prolonged discussion of that now, what I'd ask is that you let the staff know, either David or Murray -- I don't know how you

want to handle that, Murray -- by e-mail or some means, here's why that one really causes me heartburn.

MS. NEWPORT: We'll see this again in November?

MR. HACKBARTH: Yes. Let me underline that point. This is not tantamount to a vote on these. You will have a chance to look at them all again. And if you don't object today you can object in November. We're just trying to get our bearings here. David?

MR. GLASS: Again, this is to move to a standard nationwide system and eliminate some of the problems caused by having multiple automated systems and multiple systems of people deciding what is policy.

MR. HACKBARTH: I would like to avoid discussion. So if I don't see any hands, it seems to me that people think that something like this would be okay. If you have an objection raise your hand.

Seeing none, let's move on to number two.

MR. GLASS: This recommendation follows from the first one. If you have a nationwide standard system that people can understand, that can be clearly described and people will then understand the answers to, we think that this would follow and this would relieve a lot of the burden

of apprehension and uncertainty from providers.

DR. ROWE: I don't think this helps at all because it's ambiguous what official guidance is and that's really the entire question, whether or not a phone conversation constitutes official guidance is going to be the argument, so we need to be more clear on that.

MR. GLASS: Could we put that in the text, we could have some kind of discussion would constitute official guidance, Jack?

DR. ROWE: Yes, sure.

MR. HACKBARTH: Good point. Number three?

MR. GLASS: This one was to the question of, if we then reorganized the claims processing and all those related kind of contractor entities, could we then rethink the role of the regional offices? Frankly, this is because a lot of people have some questions about what is their role and are they fulfilling it helpfully? So this kind of gets to that.

MR. HACKBARTH: Objections? Number four?

MR. GLASS: This was one of the balance questions. I think the most obvious example here is in the DME world. Clearly, that just made so much sense to be a little more discriminating about what providers were allowed in. We

think that kind of principle could be extended.

MR. SMITH: It's not heartburn [inaudible].

MR. HACKBARTH: Number five?

MR. GLASS: Again, a lot of this has come about as a result I think of how funding and that sort of thing was given to the program to do this function of enforcement, and not just to the Medicare program but to others, out of HIPAA and that sort of thing. Different pots of money. Jack, you were talking about if you hand out the money differently you get different results. This is a result of how the money was handed out, and it's not clear that it's the most rational way. I think providers feel that they're being subject to multiple audits and enforcement activities and there should be a better way of doing it.

DR. ROWE: But aren't these enforcement activities from the inspector general of HHS?

MR. GLASS: They're both. That's the complaint.

MR. FEEZOR: Is that as a result of congressional direction, as opposed to --

MS. NEWPORT: To some extent it is.

MR. FEEZOR: Then make that observation. Tactfully, but make the observation.

MR. HACKBARTH: Number six?

MS. NEWPORT: I have a problem with this one. It's not the idea of testing, I want that clear. It's how you establish the process for measuring compliance. I think that's an important distinction.

MS. RAPHAEL: I don't understand what you mean.

MS. NEWPORT: The issues are, in complex organizations like health plans, is having a full audit protocol available beforehand and understanding the rules and regulations that then are the root of those protocols. Part of the issue that comes in in measuring this is not testing that so much, is how you determine the base regulations and then establish the upfront disclosure that everyone wants or reliance on interpretation that you get from CMS is that this is what that means.

And I think that I have a problem with the testing idea. I would like to be a little more sophisticated about what we offer up as rules of engagement, if you will, on this on how you develop the regs as well as what happens when you enforce it.

It's kind of a conglomeration of maybe the last three recommendations. The same idea, it's just that

testing sometimes is impossible given the timelines Congress imposes on things.

MR. GLASS: Right. I thought that's why we suggested the reasonable timelines to go with the testing.

MS. NEWPORT: I will share this with you.

MR. GLASS: You can explain it, because I don't quite understand it.

MR. HACKBARTH: We're on number seven?

MR. GLASS: I thought this was relatively common sense.

DR. ROWE: Instead of developing a mechanism, it sounds like you're going to open a new office and staff it. Why can't we just say CMS should eliminate regulations.

MR. GLASS: We could say that.

MR. HACKBARTH: Number eight?

MR. GLASS: This would include a lot of things behind it, but I guess the general tenor, I hope, is reasonable.

MR. HACKBARTH: Thank you, David.

DR. ROWE: Before we discuss this next, can we get [inaudible].

MR. GLASS: Yes.

MR. HACKBARTH: Thank you, David. This is a daunting, daunting task, both in its scale, but also for the reason that David and some other people identified. This is a problem because there are people that have deep attachments to some of these issues and their responses to problems of various sorts. The politics are very, very difficult.

The way I look at the role of the Commission is that we are part of the political process. We are not aside from it. We were asked to do this as part of the process of trying to build a consensus about change. Whether we will, in fact, succeed in helping that process or not, I don't know. But it's our role in this dance of legislation, so we'll do the best we can.

Next on the agenda is blood safety requirements for the December 2001 report. Tim?

MR. GREENE: Good morning. I'll be discussing the report mandated by BIPA under the [inaudible].

Hospital blood related costs increased more rapidly than overall operating costs over the last 15 years, due mostly to newly imposed safety requirements and the costs of technologies required to meet those requirements.

In addition, blood related costs probably increased significantly in fiscal year 2001 that just ended reflecting major price increases for products. Finally, three new blood safety technologies which I'll be discussing in a minute will probably lead to future cost increases.

Hospital payments under the inpatient PPS are, as you know, adjusted over time to reflect changes in hospital costs. These updates are set mainly by the changes in the marketbasket for hospital inputs. The current marketbasket does not include a component that explicitly and separately reflects the costs of blood products. This raises a question of the proper treatment of blood and blood-related costs under the hospital inpatient PPS.

BIPA requires that MedPAC conduct a study on any increased hospital costs from fiscal year 1984 through fiscal year 1999 attributable to new blood safety requirements and implementation of new related technologies. It requires that we examine whether inpatient PPS adequately recognizes costs and it requires that we estimate, to the extent feasible, changes in costs in the future from 2001 through 2010. It also requires that you consider possible changes to the inpatient PPS to deal with these future

expected cost increases.

This morning I'll be presenting a summary of recommendation options to start with, then a brief overview of our report. Finally, I'll be returning to a more detailed description and discussion of the recommendation options and other alternatives.

Just by way of overview, there are four options for action by CMS or the Congress that we consider. I will note them now and return to them in more detail. First, BIPA requires that when CMS next revises the hospital marketbasket, it give special attention to the adequacy of payment for blood and blood products.

I'll be discussing two alternative modifications to the marketbasket that we believe CMS could consider to meet this mandate. Second, Congress could increase the update by an amount to take account of costs of blood technologies on overall hospital costs. Although I realize you're considering changes in your update approach that would suggest that you would not support such an alternative, we did include it as an alternative to at least be considered.

Third, another alternative would be to increase

the update every year by a fixed amount, a set number repeatedly every year, as a way of dealing with these costs. This was considered by Congress last year and not adopted. But because it's been a live political possibility, we included it as something to consider.

Finally, CMS can address these costs using the new technology pass-through provisions of BIPA. In that case, it would assign a new technology pass-through payment for these presumed technology costs.

The MedPAC report presents a discussion of the development of regulations and private sector standards dealing with the safety of the blood supply. MedPAC staff, supported by Project HOPE under contract, identified relevant technologies and use during the historical period and anticipated in the future.

Project HOPE identified several major issues for the future pertaining to blood testing, methods for processing blood to enhance safety, and policies to screen donors to avoid tainted blood. It also studied three specific technologies, nucleic acid amplification testing, a leuko reduction system for removing white blood cells when blood is processed for use, and a newly developed technology

called pathogen inactivation which is a way of eliminating infections from blood whether they've been identified by testing or not. They all promised to be important and to be sources of future cost increases.

We discussed them at greater length in the report and in an appendix report presenting in detail Project HOPE's findings.

I'll be now turning to an overview of our empirical findings. We examined data on prices of blood products. We identified a measure for overall blood price, in this case the producer price index for blood and derivatives for human use. And secondly, we developed a measure of prices of blood focusing on the products used by hospitals, which we described as a hospital blood products measure.

The first, we determined grew at an annual rate of less than the growth in the marketbasket over the historical period 1984 to 1999, while the second -- our measure of hospital blood price -- increased at a more rapid rate than the marketbasket. However, these blood price indexes are very erratic over the longer period, over the full period. And more important, these alternative indexes give a very

different picture of what's going on, both over the long period and individual subperiods.

We concluded from that that we really can't reach an unambiguous judgment about the effects of price changes here on hospital costs. So we turned to Medicare hospital cost data as an alternative.

We examined two measures of Medicare blood related costs. The first is based on cost report information on facility blood related costs from the relevant cost centers for all PPS cases. The second is based on hospital bill data on these costs solely for cases of patients hospitalized who actually used blood. Both, however, give very similar results over the 1986 to 1999 period. We're choosing that slightly shorter period for data reasons.

Both grew somewhat faster than overall costs per discharge and per user respectively. However, the difference in the growth of costs between the blood cost measure and the overall cost measure is very small, less than half a percentage point per year. And as we knew, the share of blood costs in total hospital costs is also quite small. As a result, there's very little impact of these price divergences on total hospital costs for the period.

Now I turn to the policy context, which is the hospital payment system. Medicare inpatient PPS pays hospitals a fixed amount per discharge for all services provided by the hospital. Payment is made for an all-inclusive bundle of services, not for actual inputs used. In particular, it doesn't depend on whether blood or any other specific resource is used to treat any specific case.

This is important in trying to keep perspective on consideration of cost increases pertaining to just one input, whether it's important or unimportant.

Over the 1986 to 1999 period we know that hospitals were able to offset the prices, increase the prices of some inputs by reducing use of other inputs and, in particular, by shifting a good deal of care out of the inpatient setting to post-acute setting, and reducing the number of days at the end of a stay, and reducing the resources used to treat any specific PPS case. We've discussed that many times previously and in several MedPAC reports.

As a result, total operating payments per discharge over the 1986 to 1999 period increased more rapidly than PPS operating costs per discharge, leading to

positive margins over a good deal of that period. They increased at approximately the rate of blood costs. So even if we are concerned with comparing payments to the cost of a single input, payment growth approximately matches this slightly higher than overall blood cost growth.

Looking forward, blood related costs, as I indicated, probably rose significantly in fiscal year 2001 as a result of product increases in July, is where a 35 percent price increase by American Red Cross, which is the dominant supplier of blood to the nation's hospitals. Red Cross says 35 percent, American Hospital Association reports that some of its members are reporting 100 percent price increases. So this could be significant in this one year.

In addition, the three technologies which I discussed earlier are likely to lead to continuing cost increases as they diffuse in the blood-banking system and depending on the costs that are actually realized over the next several years.

The question for CMS and for the Commission then is how to prepare the payment system to deal with these current and anticipated cost increases.

We conducted a careful review of the treatment of

blood-related costs in the hospital marketbasket. We identified two alternative ways of modifying the marketbasket to reflect these costs. Marketbasket consists of 22 cost categories or components. Before fiscal year 1997 it included a separate explicit measure of the costs of blood to inpatient hospital designed to reflect the relative importance of that input.

The first alternative would be for CMS to reverse the decision it took in 1997 and reintroduce a separate cost component for blood products into the marketbasket. This alternative would essentially be to return to the pre-1997 marketbasket design.

The second alternative would be for CMS to create a new component combining blood costs with other clinically related costs. It would then identify an appropriate price proxy to use with this measure, estimated weight for the measure from hospital cost data and incorporate it in the marketbasket. We present specific information and a possible price proxy in the briefing material, but I'm not going to stop to go into them at this point.

We do think that both options would be both appropriate for dealing with input price changes and would

be preferable to the current combination of cost categories and price proxies.

Those are the options.

DR. ROWE: What are the practical differences between these two?

MR. GREENE: The first explicitly breaks out this very small category.

DR. ROWE: I understand what they do. Is there a preferred pathway here?

MR. GREENE: I don't have strong preferences between the two. I think they're both attractive in their own way. The second, of course, merges this category in a larger one and, in that sense, is less responsive to price change in that particular component. On the other hand, arguably it's more appropriate because you may not want to base a change on such a small --

DR. ROWE: Do the hospitals have a preference?

MR. GREENE: Not that I know.

MR. MULLER: I have a question. Obviously, when something is half a percent of the overall, one doesn't worry that much. But when it starts accelerating at 35 percent, compounding if that goes on for a while, it can get

to be a number that has a big effect on costs. If, in fact, it kept going up 35 percent for a longer period of time, everybody would have to take steps to accommodate and make substitutions, et cetera.

But the question I have therefore is what's the precedent that we have when something starts accelerating like that? Do we wait to see whether it goes on for an extended period of time? Do we anticipate that it might? Again, if it's .6 of a percent, I can understand people saying don't worry about that one. But you could also see this accelerating up to two or three pretty fast if this kind of slope continues.

MR. GREENE: The marketbasket is revised fairly regularly, every four or five years. I don't think they do ad hoc revisions between those periods in response to energy price increases. So the short answer is no, I don't think that they make quick adaptations.

MR. HACKBARTH: Tim, is there any rule of thumb about when they combine components, as opposed to identify something as a separate item in the calculation? Since that seems to be the distinction between those two options.

MR. GREENE: I don't know the standard rules.

MR. HACKBARTH: How big does it have to be before it becomes separate, as opposed to combined with other things?

DR. NEWHOUSE: I would think it would turn on whether we think we have a good price index for that particular component. And if we do, it probably doesn't much matter but it's cleaner to keep it separate I would think.

MR. GREENE: Just a point I made in the briefing material that's led to a lot of discontent here is that when the blood price component was eliminated blood cost was combined with chemicals and they're indexed not by an industrial chemicals index, which seems very far removed from the -- it's arguably appropriate, but when you look more carefully, it really is not an appropriate measure.

DR. NEWHOUSE: So why did they do this, do we know?

MR. GREENE: Partly because at the time the decision was made the blood price was actually declining. Certainly it was flat and it was actually declining. The weight is very small and if, in fact, the decline had continued it would have been even smaller. I don't know the

details but I'm sure it was partly a pragmatic judgment. This is the nearest thing we can put it in with. When we looked at it it didn't seem like an appropriate combination.

DR. REISCHAUER: I think the concern will continue if we bundle together a group of things simply because this is coming about because of extraordinary rise in the price of blood products and whatever price index is chosen to be appropriate will undoubtedly be lower than the increase in blood. So I would opt for the first of the two.

DR. NEWHOUSE: And here we have, a PPI for blood seemed like a reasonable index to use for this. I'd opt for the first, too.

MR. GREENE: We were careful in our proposal to include, as an alternative proxy, one that is a larger, higher level index that would at least arguably reflect the price changes of blood within it. It's different than industrial chemicals in that sense.

DR. LOOP: I think this is a very unique price change and you've captured a lot of the history but the real effect is in 2001 when it does go up 35 percent. This should be treated as an additive cost. It' snot a revenue issue.

It seems to me that this is sort of new technology and it should be treated as a pass-through.

MR. GREENE: That's another alternative.

DR. LOOP: It's such an unusual change.

MR. HACKBARTH: Tim, why don't you proceed through your discussions, since that is one of the other options and then we can get to the full discussion.

MR. GREENE: Red Cross describes this 35 percent change as a catch-up for a 20-some percent change in cost. So I don't think there's the expectation that this going to continue year after year.

DR. LOOP: I think half of it is due to catch-up and the other half is due to new safety standards, namely universal leuko reduction.

MR. GREENE: Turning to the next point, which is Floyd's point exactly, we are considering other alternatives to deal with a change like this. One would be, as we discussed yesterday, one traditional approach that MedPAC has taken is to provide a specific single year add-on to reflect the costs of technological change in the update recommendation. The proposals yesterday that you were discussing would move away from that, but I was still

considering this as a possibility.

However, the particular case that we're considering here has special reasons to have reservations about this approach. Adjustments such as the technological change adjustment are typically used for technologies that are actually used by hospitals in the inpatient setting. The safety technology we're talking about here are ones that are used by blood banks in producing blood for sale to hospitals as inputs. A small number of hospitals collect donations and produce their own blood, so we're basically talking about these as things that are used by suppliers to produce products that are then sold to hospitals. In that sense, it's very different from technologies that we traditionally deal with through the update mechanism.

Increases in input prices, such as we see here or anticipate here, are generally reflected through the marketbasket rather than through a fixed add-on. So that is a reason to have special reservation about a technology adjustment here, apart from the general considerations yesterday, which is why we considered it as an alternative but didn't fold it in as an option to directly consider.

The second alternative, this is what was

considered by Congress in the enactment of BIPA. This would involve a fixed add-on to the marketbasket, in that case a .37 percent add-on was considered by Congress last year, which would continue year after year, the same number added to the update continuously, with a sunset provision in the discussion last year. But that's what we mean when we say a fixed add-on. Here it would be, and in that case it was proposed as an explicit blood cost component. But the concern here is that this would be the precedent for many such add-on proposals. This for blood, that for another technology, that for another use.

Even apart from other questions, the precedent value is a concern.

DR. ROWE: Can I ask a clarifying question, for me at least? What are we adding it on to?

MR. GREENE: Either to the marketbasket value or the update, however you think.

DR. ROWE: Because my concern is that there are many categories of patients, either DRGs or others, in which this problem is concentrated. And there are other entire categories of patients where this is not relevant. For instance, psychiatric patients. A psych hospital should not

get an add-on to their marketbasket for the cost of blood products because they don't have a blood bank. They never give a transfusion.

So it would seem to me that we should be a little careful -- we should at least have a principle going forward that has something to do with that, so that we actually treat the problem, which is the hospitals that do a lot of cardiac surgery, cancer surgery, complex problems, and not psychiatric -- and I'm just making that up. There are other categories, there must be, rehab hospitals, I don't know, where their utilization would be much lower. I just would like to ask that we have some consideration of that as we figure out what to do.

MR. GREENE: One consideration is relative DRG payments are reset every year as part of the DRG weight setting process. Those are calculated reflecting charges two years previously. And to the extent that hospital charges reflect charges for transplants reflect, in part, the higher blood costs, those are going to be reflected down the road in higher weights and higher payments for the affected DRG cases.

DR. NEWHOUSE: What you're really asking for is

multiple marketbaskets across hospital types, and it's not clear to me that the gain is worth the candle.

DR. ROWE: No, I'm just asking for fairness.

DR. NEWHOUSE: There are other hospitals that don't use other inputs.

DR. ROWE: If all the commissioners think the psychiatric hospitals should get this, then...

DR. NEWHOUSE: We might put on our agenda for some future time, I think, looking at how different hospitals are in their marketbaskets and whether there should be multiple marketbaskets. But it reaches another level of complexity.

MR. HACKBARTH: We're very near the end of the list of options so why don't you go ahead and do the last one.

MR. GREENE: The last one is the use of a technology pass-through as an alternative way of dealing with these costs. Briefly, this raises the same question I raised with regard to the technology change to the update. The technology pass-through also was designed and enacted to deal with costs of inpatient technologies actually used by hospitals rather than for technologies used by suppliers that might increase the price of input. I'm not even sure

if it would be legally appropriate.

MR. MULLER: Now if it's a pass-through, and most of these would be inpatient costs. But for outpatient costs that would just exacerbate that 2.5 percent overrun problem, wouldn't it?

MR. GREENE: Yes.

MR. HACKBARTH: Let's turn to the question of which of these. Can I ask a question to lead that off?

Blood is clearly an input. We have a mechanism for adjusting for changes in input prices; namely the marketbasket. A case may or may not be made about whether the changes in this particular product are being currently accurately reflected through that mechanism. But I don't understand what the argument would be for adopting an entirely separate mechanism, inasmuch as this is an input, and it is a price change. What have I missed?

MR. GREENE: We're not recommending -- the options we present entirely are marketbasket modifications. I was laying out the others for completeness, to acknowledge that we considered them.

MR. HACKBARTH: I guess what I'm asking is, the advocates of other alternatives, is there any argument that

I've missed? I've not heard an argument why we shouldn't use the established mechanism for what is clearly an input.

MR. GREENE: I think there's an understanding -- what advocates have proposed is the fixed add-on proposal, which is based on their estimate of additional costs, which suggests that flat add-on, which would be, in the legislative proposal would be in effect until marketbasket changes were made. That's the logic, marketbasket changes are necessary. Until they're made, we're adding this small amount to updates.

MR. HACKBARTH: In the interest of trying to get to the bottom line as quickly as possible, are there other commissioners who can help me on this? Am I missing something, why this shouldn't be looked at as an input price issue?

DR. REISCHAUER: I think all Tim was saying was, before it can be handled that way, these advocates would like a little money.

MR. GREENE: Yes.

DR. REISCHAUER: But we aren't really speaking to the interim issue here.

MR. GREENE: No, we're not.

DR. ROWE: Can we recommend? Why can't we recommend what I think Tim is recommending, which is that the marketbasket be changed to reflect this, and then an interim payment adjustment be made to compensate for this change until that occurs?

DR. LOOP: You mean an add-on payment adjustment?

DR. ROWE: Yes.

MR. HACKBARTH: Going back to our discussion of yesterday, if we adopt the approach we discussed for looking at the base and then looking at the update, in fact that mechanism should address any shortfall.

DR. REISCHAUER: And do we think this is that serious a problem for the next couple of years? That's the real --

DR. ROWE: My concern is that there are hospitals -- all hospitals aren't equal and there are probably some hospitals where this is a very significant issue. I'm not sure they're going to be aided appropriately by this general change. But nonetheless, I would be in favor of making the change sooner rather than later certainly.

MR. SMITH: But we had a conversation yesterday where we generally agreed that our threshold for that sort

of out of the ordinary course of business update ought to be pretty high. I haven't heard, Jack, any evidence or numbers from Tim in the material that suggests this has reached that point. The marketbasket update should take care of that over time, particularly if as Floyd described, we had a one-time spike in a very small base and the update process works.

I think we set a very dangerous precedent if we begin to argue about very small items of cost with very short term spikes, that we're going to do an adjustment every time. It certainly flies in the face of our complexity argument.

DR. NEWHOUSE: David, I agree with your bottom line, but the update won't fix the weight on this issue. What I'd say to Jack though is, there is another way to get at the hospitals doing a lot of surgery, which is this will feed through to the relative DRG weight and that relative weight will go up.

DR. LOOP: In the meantime, until the index catches up with it, just let me give one statistic. For the Cleveland Clinic, a 30 percent price increase in 2002 will amount to about $2.5 million of uncompensated cost. So

that's a lot of money. So I think we need some sort of a short term fix, an update or a pass-through of some kind, because we're in the same boat with a lot of other large hospitals.

MR. HACKBARTH: Help me put that $2.5 million in context, Floyd. Is that $2.5 million for the overall operations of the institution, or is that Medicare specific, and compared to what sort of base are we talking about?

DR. LOOP: It's all patients. It's not just Medicare. If Medicare is 35 percent of it, then it would be 35 percent of that. But actually, that's not true because Medicare patients would use more blood than non-Medicare.

MR. GREENE: David, to respond to your question about magnitudes. Blood in the old marketbasket had 0.06 percent weight, so a 35 percent increase on that would be about 0.2 percentage points that would be included in the update. The question is, is that so small that it doesn't pass the threshold.

MR. MULLER: When you look at [inaudible]. It's not a small number.

MR. SMITH: I don't want to belabor this. I think we're headed toward consensus, but it does strike me that we

didn't hear anybody come in here when blood prices were falling and argue that we ought to have a negative adjustment. At 0.2 with a spike, Floyd, that looks like it is not a float but a spike, I think it's a very dangerous precedent to start, at this level, doing add-ons and pass-throughs.

MR. HACKBARTH: If we did an add-on, wouldn't we also logically have to do a take-back when the automatic processes through the recalibration of weights and the index take effect? So we'd also have to get in the business of saying, we've got to do a take-back.

DR. REISCHAUER: Unless it's sunsetted.

MR. GREENE: You could, I suppose. In the update recommendation you would have to be explicit.

DR. ROWE: I need somebody to summarize where we are for me.

MR. HACKBARTH: We're on the draft recommendation page, and it sounds like we've agreed that the issue is an input price issue and it needs to be fixed through the index. Most of the conversation seems to center on whether some interim step is necessary over and above that.

DR. REISCHAUER: But this seems to be a choice

that we have before us?

MR. GREENE: These would be a choice, right, between --

DR. REISCHAUER: Actually, although I'm strongly in favor of the first, I would suggest we leave that up to CMS and we say "or" because it's not a big deal and for technical reasons one might be preferable or easier for them to do.

DR. ROWE: But where are you, Bob, on the interim question?

DR. REISCHAUER: I'm with David. I would hope that CMS would move expeditiously on this matter and, therefore, it would go away.

DR. ROWE: If that were to happen, when would the change become effective?

MR. MULLER: What I heard Joe say about the DRG re-basing is about a year and-a-half lag.

DR. NEWHOUSE: Not the re-basing; the weights.

MR. MULLER: The re-weights. The DRG one is about --

DR. NEWHOUSE: I believe it's every year.

DR. REISCHAUER: I would presume if CMS can decide

to drop blood out, it could decide to put it back in and this could be in next year's index.

MR. ASHBY: Just a quick point of clarification on the timing here. HCFA does process every five years, and I guess by the luck of the draw the fifth year is here. HCFA is committed to doing a -- reconstituting the marketbasket this very year. So the process is underway. The timing is really quite good.

DR. ROWE: When would it come into effect?

MR. GREENE: The year after.

MR. ASHBY: I believe it would come into effect about one year from today, October 1st of 2002.

DR. ROWE: So then the question is whether -- so now we've defined interim. It's one year. And the question is, what's the sense of -- whether there's sometihng to be done during that year, right? That was what was --

MR. ASHBY: Yes.

DR. ROWE: But now at least we know it's one year.

MR. ASHBY: But let me remind you also, we talked about reviewing the adequacy of base payment rate yesterday which we have not yet done here, and this sort of fits into that category. There's kind of an adjustment to where we

are today, today really meaning a year from now because that's about as fast as the process works. We might want to think about it in that context, given all the other things that affect the rate for inpatient payments.

MR. HACKBARTH: Given the one-year duration of interim, and given that we've got automatic mechanisms in place. Given that logically if we make this exception we open the door to other similar claims and we have to go back logically and deduct it from the future, it seems like a lot of complexity and risk in terms of opening the door, to take for a one-year fix on a relatively small component in the overall cost structure.

I say that with sympathy to the institutions, but we've got mechanisms to fix this problem. This is just one example of something that can come up over and over again with various inputs.

DR. REISCHAUER: Would an add-on have to be a legislative change?

MR. GREENE: What we'd be saying would be, the Congress should consider it when it next legislates.

DR. REISCHAUER: Because I think realistically speaking, this probably wouldn't happen between now and

January 1st, so it would be an after-the-fact repayment. I think it's just way too much trouble if we're urging that this be adopted within the next year.

MR. HACKBARTH: I missed the first part. So your point is that the add-on would also take time, and wouldn't be immediate, so by that time the other mechanisms are in place; is that right?

DR. REISCHAUER: Yes. CMS has set the payment for next year.

DR. ROWE: One way to do it -- can I make an alternative suggestion? I'm just trying to think about it here. If we think that there's going to be an interim period where there is a modest disadvantage, particularly to those institutions concentrated in this, and we don't think there's an effective mechanism available to deal with it easily without all kinds of other problems, is it reasonable when the marketbasket change is made to take that into consideration in the amount of the change that is made, to sort of pay back or compensate it? Can that be done? Professor Newhouse is shaking his head no.

DR. REISCHAUER: I guess my question would be, why start with this year? Why don't we go back to the last 10

years, and then the sine might be different.

MR. SMITH: And wouldn't the consequence, the logical consequence of that argue that we ought to look at every modest that might have affected prices because of divergence from the marketbasket every year and then do a retrospective adjustment?

DR. NEWHOUSE: Plus it goes beyond price. If you have a new -- stents come in in the mid-'90s, they add on to the cost of doing angioplasty. It's a lag until that gets in to reimbursement and the hospitals just have to eat it.

MR. SMITH: I can't imagine, Jack, that if you took what you just recommended and abstracted it so we're about all inputs, that you'd support that kind of adjustment for --

DR. ROWE: I'm just trying to figure it out. I'm thinking about your spike argument. I'm thinking about other things that are spikes, like Y2K, this kind of thing. I remember when we used to add up pluses and minuses of things that we took into account. We said, that cost the hospitals X during that year so we added something. We did that. This group did that as I recall. So it's not as Alice-in-Wonderland as it might sound. But it sounds like

it would not be feasible or appropriate to do with respect to this one thing, with respect to this one case. But that's how I got to --

MR. HACKBARTH: In the interest of allowing people to catch their planes, because as you'll recall from yesterday we have two items that need to be added on: the cancer hospital issue and a final decision on the consumer coalition issue. We need to squeeze those in this morning. We're not going to take a vote today. We had never planned to take a vote today on this issue. So it will be back before us next month.

What I'd suggest we do is set it aside for now, have the staff nail down some of the factual information around the timing issues so that we can be absolutely clear on how long interim is, as Jack puts it. Then we'll come back at our November meeting and actually have the final vote and decision on the issue. Are people amenable to that?

Floyd, if you have an issue that you would like the staff to research during that period, go ahead.

DR. LOOP: I think that the dollar impact, that the DRG weights are something we should look at, and timing.

So there are three things, unless somebody has some others.

MR. HACKBARTH: I'm sorry, I didn't hear the last part.

DR. LOOP: The timing of this if we put it in the marketbasket.

MR. HACKBARTH: Thanks, Tim.

What I'd like to do now is turn to the two issues that we set aside yesterday, beginning with cancer hospitals. We'll do that one and then we'll do the consumer coalition issue, and then conclude with the June report on modernizing the Medicare benefit package.

DR. ROSS: In terms of where we left off yesterday for the discussion on the recommendation on cancer hospitals, what staff heard was general support for the recommendation with some concerns perhaps about the tone in the text, and you wanted some additional information on the shares of inpatient and outpatient Medicare revenues for the cancer hospitals. What we proposed was to bring you that information that you asked for, get a decision on the recommendation, and we'd like to make revisions to the text as we normally do for a report and circulate a pre-publication review, and not come back to this in November.

We'd like to get resolution on the recommendation today.

DR. ZABINSKI: This sort of reminded me of eight years ago when I was working on health reform, get the numbers and get them quick. What we have here are financial information for eight cancer hospitals that have had their 1999 cost reports fully processed. Right now, as you know, there are 11 cancer hospitals. In '99, there were actually only 10, and two of them have yet to have their 1999 cost reports processed. So that's why we only have eight up there.

DR. ROWE: Two years later?

DR. ZABINSKI: Two years later. Jesse Kerns assures me that's not unusual.

In the first column it shows the variation we have in the Medicare outpatient revenue relative to total Medicare revenue. As I think Jack suspected yesterday, there is quite a bit of variation. They go up to pretty high numbers to fairly low ones.

The second column we just have total overall margin. This is not Medicare margin but total margin itself. Once again this is quite a bit of variation there; as low as minus 17 percent and up to positive 10 percent.

Then the final column we have Medicare overall revenue relative to total revenue. As in the first two columns there is quite a bit of variation across the hospitals.

I guess the bottom line here is that it appears that some hospitals could be affected much more by a hold-harmless provision, or perhaps lack of one.

MR. MULLER: Is H accurate?

DR. ZABINSKI: Yes.

DR. ROWE: You told us yesterday, Dan, or your colleagues told us yesterday that there was a figure with the average for all hospitals for outpatient versus inpatient for Medicare. What was it again? Was it in the 30, 15 percent range? That's the relevant number we need to compare this to.

DR. ZABINSKI: What are you asking again?

DR. ROWE: For all hospitals, what is the outpatient revenue over total revenue for Medicare?

MS. RAY: It's around 17 percent.

DR. ROWE: Thank you. So that the argument that some cancer hospitals are much more dependent on outpatient than the average Medicare hospital is reflected in the

difference between these numbers and 0.17; is that correct? That's the number we need. The first column versus 0.17. So that a hospital at 0.23 or 0.19 would be like an average Medicare hospital and they're not disproportionately hurt. Whereas one at 0.63 is obviously disproportionately --

DR. NEWHOUSE: We probably should take H off the slide since only 1 percent of their revenue is Medicare.

DR. ROWE: Didn't we see this yesterday? Somebody showed us this bar graph yesterday.

DR. ZABINSKI: The first column averages out, like Nancy says, to 32 percent for cancer hospitals. Overall it's about 17 percent.

DR. ROWE: Thank you.

MR. MULLER: But the 17 is a Medicare number, and 32 is the total number, right? This is total outpatient versus --

DR. ZABINSKI: Medicare.

DR. ROWE: This is all Medicare. So this is comparable to 17.

DR. REISCHAUER: But by and large for the third column over what is the average, about one-third?

DR. ZABINSKI: It's about 18 percent for cancer

hospitals.

DR. REISCHAUER: No, but for all hospitals.

MS. RAY: About 30 percent.

DR. REISCHAUER: They have a Medicare problem, but Medicare looms smaller in their overall activity.

DR. ROWE: Right. They may be disproportionately outpatient hurt but they're not disproportionately Medicare disadvantaged.

DR. NEWHOUSE: This is your observation: the very old are kept more in the community.

DR. ROWE: Where they do get excellent cancer care. That was the second part of my observation.

MR. HACKBARTH: So let's review where we are. Put up the draft recommendation from yesterday.

DR. ZABINSKI: As it says here, until better data are available, the Congress should maintain the current hold-harmless provision for payment for outpatient services in cancer hospitals.

I guess one thing staff proposes to stick with this recommendation and then in the text add discussion showing that some of these hospitals potentially could be affected much more by a lack of a hold-harmless provision,

and that that particular issue should be considered when the hold-harmless provision is considered in the light of better outpatient PPS data.

DR. ROWE: I'd like to withdraw my objection from yesterday, given these data, just to move things along, if that helps. I think we have data on eight, not 11. One of them is irrelevant; it's 0.1 percent. So we have data on seven. It's not worth breaking this up into different subgroups. None of these are disproportionately Medicare affected. It's just not worth it at this point. So I think I've made my point and I'd like to fold.

DR. NEWHOUSE: Could I ask a question? On the inpatient margins you showed us yesterday, the minus three -- I'm sorry, total margins. Are those hospital weighted or revenue weighted?

DR. ZABINSKI: The way we figure margins it's payments minus cost divided by payments.

DR. NEWHOUSE: I understand. That's at the hospital level.

DR. ZABINSKI: Jesse says that they're revenue weighted.

DR. NEWHOUSE: Then I'm still concerned about

those total margins.

MR. HACKBARTH: Just one factual question before we move to a final decision on this. The current hold-harmless provision lasts until when?

DR. ZABINSKI: It's permanent.

MR. HACKBARTH: Okay, that's what I need to know. Are people ready to vote on this issue?

DR. REISCHAUER: There's a question of, what is the issue here? We're saying Congress shouldn't take action to undo something that is permanent.

MR. HACKBARTH: They asked the question.

DR. ROSS: That's the question put this us.

DR. NEWHOUSE: Now let me ask what the better data are we have in mind. I've forgotten.

MS. RAY: The outpatient PPS data, actual --

MR. HACKBARTH: Experience in their PPS.

MS. RAY: If I can just address Bob's question though. It was the Congress that included this in the BBRA to hold cancer hospitals -- to have this permanent hold-harmless. So they're I guess asking, should they continue this.

MR. HACKBARTH: Are ready to vote? All in favor

of the draft recommendation --

DR. ROSS: Do the opposeds first.

MR. HACKBARTH: All those opposed to the draft recommendation, please raise your hand.

All in favor?

Abstaining?

Okay, thank you.

DR. ROWE: I'm delighted that after four years I've actually got other commissioners to pay attention to the cancer hospital issue. I consider this a victory.

MR. HACKBARTH: Consumer coalitions. Susanne?

MS. SEAGRAVE: I just wanted to remind everyone that we had discussed yesterday the potential for consumer coalitions on the information side to cause confusion, and their limited potential for success in the purchasing side. Based on those two things we recommend that the Secretary not conduct demonstrations of Medicare consumer coalitions.

MR. HACKBARTH: I'd like to offer a proposal. Not on the recommendation, per se, but on the context of what we say in the letter itself, the preamble, if you will, to the recommendation. I'd like to see a few points made. One, that it's the sense of the Commission that getting

appropriate useful information to Medicare beneficiaries is a very important issue. It's a very serious problem as things now stand. Notwithstanding that though, it is -- actually let me hold off on that because it really pertains to the recommendation.

Second, again to put this recommendation in context, is that we were asked a narrow question about whether this should be a top priority as a demonstration. So from my vantage point, we are not passing on the merits of these coalitions, whether it be the information coalition or the purchasing coalition, per se. The question that we're addressing is actually whether they are at the top of the list for very scarce Medicare demonstration dollars.

So to me those are two important points of context that ought to be emphasized.

Now let's turn to the draft recommendation. Is there any further discussion of this that people want to have?

MR. FEEZOR: Glenn, just on your context, if you will. I think also it might be nice to complement the importance of Medicare eligible education, to recognize that in fact there is federal effort or support and that it might

be improved, or the Secretary might in fact look to make sure that the existing educational effort in fact leverages as much of local resources and activities that it might, and some of the concepts that were presented by some of the speakers on that.

But anyway, just basically I guess in essence that the Secretary might make sure that, whether it's the sharing of best practices, which my recollection is they do do in their meetings, and the SHIP programs. But the importance of that and making sure that that's constantly being reinvigorated or improved, looked to improve, would be also encouraged.

MR. SMITH: Glenn, briefly, I think the recommendation ought to be modified to incorporate the notion that given the scarcity of Medicare demonstration resources, funding consumer coalitions should not -- rather than this. As drafted it's inconsistent with your notion that context ought to establish, there may be something good to do here. We should simply say, we shouldn't spend money on it now because it doesn't jump to the top of the queue. I would agree with Allen's modification of the context stuff, and if Sheila were here she would, I think, also

agree with Allen and with you, and she wanted to be on record. Since she can't vote, I just put her on record.

DR. ROSS: Perhaps in November when we go to Powerpoint this would be much easier to do, but for the moment we're pencil and paper. To take your suggestion that would be revised to read then, given the scarcity of resources -- we may find a slightly different way of phrasing that thought -- the Secretary should not give priority to demonstrations of Medicare consumer coalitions, as opposed to should not fund?

MR. SMITH: I would even say, should not support or should not fund. But I think we ought to set it in the scarcity context, sort of the relative value.

DR. ROSS: Okay, given scarcity of resources for demonstrations, the Secretary should not fund demonstrations of Medicare consumer coalitions.

MR. HACKBARTH: Let me offer one other point that maybe goes in the first part, the context. One of the questions that I have about this as a high priority use of demonstration dollars is whether this is even the sort of thing that is amenable to demonstration. The nature of these activities, in my view and my experience, is that they

are very dependent on the people involved, the local market dynamics, and the like. You could do a demonstration in Rhode Island and know very little about whether the mechanism would work in San Jose or some other part of the country.

When we use our demonstration dollars, limited as they are, we ought to be trying to learn things of broad applicability, and I don't think this passes that test.

DR. REISCHAUER: I think that's true of almost everything and that's why when you do a demonstration you might do it in eight sites that differ, to get some feel for how something would play out nationally.

DR. ROSS: As distinct from a payment system?

MR. HACKBARTH: Payment systems, for example, I think are less dependent on the local personal dynamics and institutional structures.

DR. REISCHAUER: No, absolutely. I'm not saying that that isn't the case. But does that mean you rule out demonstrations on anything that has a human or a local --

MR. HACKBARTH: You're right in saying we need to be --

DR. REISCHAUER: That we shouldn't do it? We have

the Medicaid program which is different in every state, and yet we run demonstrations all the time.

MR. HACKBARTH: I won't insist on inclusion of this point if there is significant disagreement about it. But to me it goes to the issue of priority. That in fact when you have very limited resources I think that this is not something that you use to rule out forever a type of demonstration, but it certainly deserves weight in considering what priority you give to things. That was my only point.

DR. REISCHAUER: I would hope we would use the word resources rather than dollars. You've been switching back and forth. Because from my perspective, the limited resource is really management and administrative capability at CMS with everything else they have on their plate.

MR. HACKBARTH: Your point is well taken.

DR. REISCHAUER: In terms of dollars, this is a trivial amount of money.

MR. HACKBARTH: I agree, Bob. Any further discussion?

So the vote is on the draft recommendation as amended by Murray. Do people need to hear that again?

All opposed to the draft recommendation as amended?

All in favor?

Abstaining?

Thank you.

Last, but certainly not least, is the draft outline for the June report on modernizing the benefit package.

MS. THAMER: Julian and I are here to discuss MedPAC's June 2002 report which is going to focus on the Medicare benefit package. We sent you an outline of the issues that we delineated that were related to the June 2002 report as we saw it, as well as we sent you different types of recommendations that could be made based on varying levels of specificity. Some recommendations could be very general overarching types of recommendations, and others could be much more specific.

The topic of the Medicare benefit package is a very important, interesting, and very critical topic. It's also a very broad topic that could go in a lot of different directions. Given our resources, we really wanted to focus our efforts, and we hope in this discussion to find out

three important things from the Commission.

One of them is what approach you'd like us to take in looking at the Medicare benefit package. Secondly, what the Commission would like to achieve in the June 2002 report. And third, what, if any, types of information you think you would like to have to make appropriate recommendations.

Before we begin I'd like to just very quickly set the stage with a few salient points about the background of the current Medicare package. As you all know, when Medicare was enacted in 1965, the benefit package was designed at that time to emulate that of the working population. The same benefits were offered in basically the same manner.

As such, they focused on acute care services, especially hospital services. The main objective was to limit financial liability of elderly beneficiaries and their children. It was not designed with the health needs of an elderly population in mind, and provisions at that time did not address problems of the chronically ill as well as other preventive services and other services. In the ensuring 35 years there hasn't been any major restructuring of the

Medicare benefit package, although there have been major changes in the benefits that are offered to the working population.

Calls to modernize the Medicare benefit package have usually cited substantial financial liability and risk of the beneficiaries. For instance, that less than half of all health care costs are borne by Medicare, and that there's no maximum spending to protect against catastrophic costs.

Another issue that's often cited in the need to modernize the Medicare benefit package is better access to modern medicine for elderly beneficiaries, particularly, the lack of outpatient drug coverage, chronic disease management techniques, and other innovations in geriatric medicine.

Finally, there are concerns about how appropriate the benefit package is for specific subpopulations, like the disabled and those with end-stage renal disease.

We thought a good place to start this discussion might be to discuss the three options that we sent you. These were of many possible options and approaches of what could be achieved with the June 2002 report.

Just to quickly summarize the three options that

we presented were that the June 2002 report could either develop a conceptual model that would assist policymakers to examine issues around the Medicare benefit package. Secondly, we could go further and develop specific recommendations, both in terms of the content and/or the financing for reforming the benefit package. Or third, we could delineate the next steps in terms of actually implementing a reformed or modernized Medicare benefit package.

One or more of these options are possible. So we thought this would be a good place to start the discussion.

MR. SMITH: An information question. When folks in '65 looked at the working population's coverage what was the model? Was it folks covered by an employer plan? Was it what you could buy across the table at Blue Cross?

MS. THAMER: I think it was the Blue Cross-Blue Shield plan.

MR. SMITH: How well does that -- if we tried to say today, we want a model, the coverage of the non-aged population, what would we do with folks without coverage? Or the changes in coverage as we've moved from more defined benefit to more DC-like options? I wonder as we think about

the, yes, the update ought to reflect what folks did in 1965, whether or not we also need to think about what it is we're trying to emulate, and what are the differences at this moment.

MR. HACKBARTH: Other comments?

DR. REISCHAUER: I would think that what we should have here is a discussion of why we're concerned about this. In number two you listed a lot of more specific things than I would come up with as categories. I can see that there are four reasons why we might want a more expanded benefit package. The first is it would result in better health outcomes. When you cover something and you don't cover others that are proven, important inputs to good health like prescription drugs, clearly the end result can't be as good.

Secondly, you might want a more expansive benefit package because it's cheaper. What I mean is, it's cheaper to buy one coherent insurance package than it is to paste together two or three, as 87 percent of the people do.

Third, because it's easier to administer. That is both from the individual's perspective, the beneficiary's perspective and from the perspective of CMS and whoever is running that supplemental insurance policy, and providers.

You don't have to ask, who's going to cover this other part. You know.

And finally, just reveal preference of the beneficiary, that they would like something better. That in a way is separate from everything else. If people want something, you should provide it in the form that they want. That's a way of organizing really what are then a lot of examples or dimensions to these items in number two.

MS. THAMER: So in some of these, in the second and third example that you gave, you're looking at it from a societal perspective.

DR. REISCHAUER: Absolutely.

MS. THAMER: That's rather than just from the Medicare perspective.

DR. REISCHAUER: Right.

DR. NEWHOUSE: As I understood what you were asking here, you were proposing to develop the conceptual model and you were looking for guidance on going forward to specific recommendations on services and implementation. I didn't feel I knew enough at this point to comment on that. I think I would encourage you to start out that way and see how it goes.

I thought it we do get to specific recommendations there's an obvious problem that it could become the overloaded Christmas tree. I thought it was going to be incumbent on us to have some idea of cost on any specific benefit package. I don't think we want to get to how to finance the cost, but at least we should have some sense of order of magnitude of cost.

DR. LOOP: These are just some random thoughts as I read through this. One was what Joe just mentioned, and that is that you have to attach some financial projections any time you enlarge the coverage.

But let me start on the second page there under 1(a) when you're talking about catastrophic costs. There's a definition of a catastrophic illness, but it seems to me as the population ages that there are many chronic diseases now which if you add up the cumulative cost that these become catastrophic illnesses. The other point there -- so I would like to know how you define catastrophic costs and what percent of all cost is termed catastrophic.

The other thing is that you say Medigap policies are becoming increasingly unaffordable. If that's true, are there trends, people are buying less Medigap, or how do you

support that?

Just as a practical point, by the time someone reaches Medicare a lot of the prevention or preventive measures are lost. If you're 65 and you've smoked four packs a day for 30 or 40 years, there's not a lot of prevention at that age that's going to help you. So I wonder whether we're going from health care -- I understand what you want to do is you want to get out of just the episodic illness. But you can also get a little bit too far into public health, because there's some -- back to the common sense part, there's a way where disease prevention actually stops as you get to a certain age.

So I don't know whether any of that is helpful, but those are my comments.

MR. PETTENGILL: I guess the only response I would make to that is that people become eligible for Medicare, the non-disabled, the elderly become eligible at 65 and many of them will be living another 30 years. Certainly I hope to. And if I have high blood pressure or I have high cholesterol or something like that in my fifties and early sixties and I roll into Medicare and Medicare doesn't pay for any of the services that are designed to prevent the

effects of those problems, then we've lost something. So it's relevant in that sense, even though the opportunities for effective prevention may decline.

DR. LOOP: Right, but that is largely secondary prevention as opposed to primary prevention.

MR. PETTENGILL: Yes.

MR. FEEZOR: I guess one observation. I am a little concerned when we set our minds toward saying, how can we bring Medicare up to what current coverages are? I think we need to do a little bit more crystal-balling and looking how they should --

With that, a few of us out on the left coast are trying to think through what, at least for the active employees, a better design, and quite honestly, a better reimbursement of the providers to actually manage care, manage the disease burden, and actually design, whether it's an open enrollment, rethinking that where you try to get commitment of a patient to a provider or provider system over a longer period of time, of where you begin to actually pay specific providers for three-year durational treatments, or care management I should say as opposed to treatments.

All I'm saying is, let's not get out mind-set of

looking at where it is now because it very well -- I'm not sure quite honestly that we have the answers now in our health benefit design, and fear that particularly given the economy that that may be a little bit -- so let's stretch ourselves just one second. We're still fumbling with it, but it may be helpful along that line to share some of the information that the Pacicic Business Group on Health is getting ready to try to trot out as it tries to push the margin a little bit and how to rethink that.

The final thing is, and I think certainly both Joe and Floyd's comments about needing some sort of dollars -- it could be if we get into the Christmas tree decorating business that we think of tiering those optional packages. If that's the case, then I think it offers at least a construct by which Congress could give in to its real instincts to have all sorts of great designs. But something between its payment, maybe rethinking the tax consequences specifically with regards to maybe longer term care, that is something that we could at least allow Congress to think -- think through for Congress a little bit on that.

DR. REISCHAUER: Going back to your outline, there's a whole lot that would be covered here and I was

looking through it thinking, what would I drop? What I'd drop is number seven, the various restructuring approaches most commonly advocated for reforming the Medicare benefit package. That's a book and-a-half in and of itself. It strikes me that it's not that relevant.

There is one relevant issue and that is the question of whether Medicare should have a standard benefit package or some choice. But that can be mixed with almost any one of the structural alternatives. Even that gets into a very complicated set of both practical and philosophical issues. So I would treat that issue pretty succinctly, given what else we have on our plate here.

MS. THAMER: That's very helpful. That narrows it down a great deal.

MR. MULLER: Since the cost and benefit question is going to be with us for many years to come, as it has for many years in the past, and just some of the words Allen has spoken to. In looking at the clinical management processes as part of the benefit package I think is something that would be fruitful for us to look at. Obviously, some of the efforts at capitation have been politically rejected in the last five or seven years.

But the ways in which -- the demand for services I think is just going to continue to go up for all the reasons that people have written aobut, including Joe and others in terms of the advance of technological and the consumerism. I think if we put into the benefit package as well as some consideration of the clinical management options that might be available, wehther it's stuff that's been tried out the last few years like disease management and some of the other kinds of experiments with overall case management, care management. But I think making that part of the benefit package, the modernization package would be fruitful for us to look at.

DR. LOOP: In the goals of modernizing the Medicare benefit package, I would also add to that A through G is beneficiary education, because that's going to do more for prevention and even disease management if you have an educated beneficiary public. I think that should be included.

MR. FEEZOR: Is that education or engagement?

DR. LOOP: Isn't engagement part of education though?

MS. THAMER: You also mean self-management,

education in self-management as well as education in terms of lifestyle and behavior?

DR. LOOP: Yes, all of those. We can probably say you have to be educated first about, not so much accessing the system, but their own disease prevention, early, before they get to Medicare.

MS. RAPHAEL: I just wanted to build on the point that David made and just trying to understand what it is we're trying to emulate and what's happened in the employer-based insurance field. But I'd also like to imbed in that something that I think is important, which is in the employer-based insurance field, as an employer we will change our carrier every two to three years. So carriers don't have any incentive really to do a lot of the things that we might be examining in this chapter. But Medicare is the carrier forevermore. I think that is very important in looking at the equation here.

MR. SMITH: Three quick points. I think Bob is absolutely right about seven, and I think some of the same concern is in part three of the outline. That there may be too much program design in three rather than a focus on the benefit package.

Carol raises a point which I had also wanted to raise, except I'd broaden it a little bit. One of the things we ought to think about as we think about the Medicare benefit package is integration with the rest of the health care insurance delivery apparatus. We've raised that question in a variety of other ways. We certainly ought to think about the implications for system integration as we think about changes in the benefit package or the way it's delivered.

This is my last point. The third point is, following Allen, I would add long term care to part two.

MS. THAMER: The goals in modernizing?

MR. SMITH: Right.

MS. THAMER: And what would you say about it?

MR. SMITH: It seems to me that section two at the moment -- it's a wish list that runs some risk of turning into a Christmas tree. But as a wish list it's incomplete without long term care on it.

MR. PETTENGILL: David, could you be a little bit more specific about what you have in mind when you're talking about the system integration issues? Because I can see a lot of different things that we might want to worry

about in the report, but I'm not sure which of them you're thinking of.

MR. SMITH: I'm not sure, Julian, I know how to be terribly specific. It seems to me that a couple of things that we know are going on and will continue to go on at a greater rate. Medicare will become a bigger and bigger part of the payment apparatus for the health care system as a whole. What are the implications for how Medicare pays, and what it pays for the rest of the system, which in relevant terms will be getting smaller? As baby-boomers age, as all of us become beneficiaries rather than commissioners, that will have an effect on the health care system beyond the boundaries of Medicare.

I don't know what's going on in the Medigap market. The questions Floyd raises are correct. But as we change the Medicare package that has implications for collectively bargained plans, for employer-provided retiree plans. So there are consequences, systemic consequences and in some cases financial consequences beyond Medicare that will intensify. Simply for demographic reasons we ought to pay attention.

MR. PETTENGILL: VA, DOD, secondary payer.

There's a whole bunch of things.

MR. SMITH: Right.

DR. WAKEFIELD: I think the criteria section I thought were really important, the very last section in this document. So much so I almost thought it might be the first section that we think about in terms of informing policymakers. So two comments about it.

First of all, it might just be the wording and me for the first item (a), does it advance the practice of medicine, et cetera. I was looking at that a little bit more broadly. And then, does it high quality health care practices using the least costly means to arrive at a given beneficiary health outcome maybe, or beneficiary outcomes? I'm not sure. But it's much more than, in a sense of just the practice of medicine, I think. We're talking about care delivered in different settings and yada, yada. So you might think about that a little bit.

Then I wondered, was there any particular reason why you might not have included a criterion that talked about the need for policymakers to either consider or maintain comparability or equity among beneficiaries or across beneficiaries in terms of benefits and cost of the

program?

MS. THAMER: We did not. We just didn't include it.

DR. WAKEFIELD: Would you think about that?

MS. THAMER: Okay.

MR. HACKBARTH: We're getting to the point where I feel we're going to start to lose commissioners, and this is a report where we have some more time to develop. Could I change the diretion here for a second and get people to turn to the last page which has three categories, types of recommendations, to try and define the right pitch, if you will, here. I'd like to see here what response commissioners had to the type -- where we ought to be headed. And if you don't have any thoughts, I guess that's okay too. But I wanted to make sure people had the opportunity.

It doesn't sound like we're getting any reaction.

DR. ROSS: Let me just tell you what we were trying to do there, because we've brought you outlines before and they're almost, by their nature, unobjectionable. But we were trying to get at issues we talked about at the retreat in terms of what will be the value added for the

Commission's report. Just to think about these recommendations as 30,000 feet, 5,000 feet, ground level, which could you envision making, and whether any of these either set off peals of joy or terror in your hearts. The answer is, I guess, none of the above, and you want more structure. So we'll bring that to you.

MR. HACKBARTH: The issue, of course, isn't the content of what's here. We're trying to flesh out our vision of what we're trying to produce in June.

DR. ROSS: Because obviously we would like to go beyond endorsements of motherhood and apple pie and get to something more specific. Then the question is, how specific ought that to be.

DR. NELSON: Murray, if you want opinions on that issue, I like the type B recommendations because you get into a hornet's nest of turf battles and all that we just don't really need to insinuate ourselves in if we get very heavily into type C.

DR. REISCHAUER: Some of the type C recommendations really could be text of the discussion of the type B.

MR. SMITH: My sense, Alan, was that B was better

than A, and C was better than B. And we ought to shoot for C and we'd end up at B with exactly what Bob described.

DR. REISCHAUER: I can see some type A recommendations, a mix of A and B.

MR. FEEZOR: Glenn, if I might, just one context, following on David's comment. We assumed that, and certainly the Medicare supp market is going to be there, but again you referenced it almost in passing, the importance of employment-based coverage to supplement on the retiree.

I think we need to at least put in the broader context what is happening to that, because I think that may cause Congress to revisit, if it is in fact going to visit how this program is designed. It was designed in the '60s because there was almost a total absence of coverage for people of that age. While we have greater prevalence of that now, either self-purchased or employment-purchased, certainly the employer sponsored is on a very drastic down -- it's got a glide path -- so hence, I think that context needs to be highlighted as one of the issues presented in our report.

MR. HACKBARTH: Mae, Julian, anything else you need from us in terms of direction?

MR. PETTENGILL: No. We'll get much better reaction when we put a draft in front of you and we get to see what we're suggesting that you say and see whether you like it. Thank you.

MR. HACKBARTH: Okay, public comment period now begins. Any comment from those in the audience?

MS. SHULMAN: I'm Rosalyn Shulman with the American Hospital Association. The AHA wants to thank the MedPAC commissioners and staff for their attention to regulatory reform and relief as well as blood costs. The regulatory reform and relief issue has been an important one for our membership, as evidenced by the PricewaterhouseCoopers study on patients and paperwork that we made available to MedPAC commissioners. We look forward to working with you to achieve regulatory reform.

Regarding blood, the AHA is committed to the continued safety of America's blood supply and believes it to be a critical factor in providing high quality care. New technologies have helped us to improve blood safety. But of course, this has led to inreased blood prices as well. Unfortunately, blood price increases have not been adequately captured in the Medicare marketbasket or by

MedPAC's update process.

Hospital blood costs have inreased significantly in recent years due to a number of factors that are intended to bolster the safety of the nation's blood supply, including numerous screening tests and confirmation tests mandated by FDA as well as blood donor deferral requirements intended to protect against variant CJD as well as other requirements.

But blood prices have also risen dramatically due to things other than FDA mandates. For instance, the American Red Cross, which supplies one-half of the blood used by hospitals, recently changed its policies so that hospitals will only be able to purchase leuko-reduced red blood cells. This increases, as we understand it, the per-unit cost by about $30 to $40. This is not a change just in price, it's actually a change in product.

This and other policy change by the American Red Cross have resulted in an average 35 percent increase in the pricce of blood. However, as staff mentioned, many of our members are reporting much higher increases than that; increases as high as 80 percent of 100 percent.

The price of blood is expected to increase even

more in the near future as new screening tests are formally mandated by FDA. Nucleic acid testing, or NAT, is one example of such a new technology. NAT testing costs $8 to $10 per pint of blood. Once NAT testing is fully licensed by FDA we expect the price for this test to double. The price will increase even more if FDA requires that individual testing replace current pooled testing.

Viral inactivation is a technique under development that holds a great deal of promise, but it is expected to increase, double or triple the price of blood.

Further, the FDA recently indicated their intent to put into place a stricter donor deferral policy in the next year which will drive costs even higher. The American Red Cross' donor deferral policy instituted this month is even more strict than the FDA's proposed policy.

So consistent with comments that were made today by MedPAC staff and commissioners, the AHA believes that the fact that the Medicare hospital marketbasket does not include an explicit measure of blood price fluctuation means that inreases in the price of blood are not appropriately accounted for in Medicare payments to hospitals. Therefore, the AHA strongly urges the Commission to recommend that CMS

revise the marketbasket index to include an appropriately weighted blood and blood product PPI.

In addition, any advancement in blood screening and processing technology that is not captured in the PPI needs to be explicitly considered for the S&TA adjustment process. In this way, Medicare payment policy will finally support the public health imperative of a safer blood supply.

Thanks.

MR. HALL:

Good morning. My name is Stephan Hall. I'm with the Advanced Medical Technology Association formerly known as HEMA. I'm accompanied today by Guy King, formerly chief actuary at HCFA who's helped us prepare our comment today.

First of all I wanted to commend the MedPAC staff for their very diligent work in preparing this report, and very thorough consideration of the issues. I wanted to share with you just some key points of the written statement that we provided to this commission.

AvMed fully supports a careful review and revision of the Medicare payment methodologies to help ensure that there's adequate reimbursement for safe blood products. We

strongly support the use of a separately-weighted producer price index for blood products, with an appropriate weighting factor in addition, in the annual marketbasket index calculation by CMS.

However, we do not think this is the only remedy that this body nor CMS should consider. We think there are other steps that ought to be taken, including potentially improvements in coding and examination of the billing behavior by hospitals. That would help ensure that the full cost of providing transfusions are captured in our system and appropriately reflected in the annual recalibration process.

I won't review at length the factors that contribute to blood costs because many of them have just been mentioned, but I would like to mention the unique economics of the blood collection market. The first point to share there is that this is a predominantly non-profit collection market. That is, the entities who produce the blood products for sale to hospitals operate on a not-for-profit basis.

At the same time, the markets for blood products are extremely competitive and hospitals with narrow budgets

can be extremely sensitive to changes in the prices of the blood products they purchase. This price sensitivity can lead hospitals to struggle in purchasing safer technology-enhanced blood products.

Further still, there may be delays in the pricing adjustments by the non-profit blood collectors to reflect the cost of producing the blood. There may be a lag in the market price that a hospital pays. I don't have concrete evidence to demonstrate this, but we did do an analysis of data, which I'll mention in a minute, that showed costs among 35 community blood centers as compared to the producer price index that's currently released by the Bureau of Labor Statistics.

This phenomena of costs being greater than prices may be particularly acute when there are new regulatory requirements or new safety mandates that public health concerns demand for adoption by the blood collectors. There's also anecdotal evidence that hospitals, once they have purchased blood units, do not bill and charge for technology-enhanced blood products in a fashion that's consistent with the way in which other services are billed.

For tehse reasons, the economics of producing safe

blood products is very complex and does not follow the same pricing and purchasing patterns as other technology-enhanced items. So one could imagine a first loop before the DRG reweighting loop occurs in which prices are delayed by several years before they are updated to reflect actual costs.

As mentioned earlier, medical technologies are a critical element in blood safety, and over the past decade they've made significant contributions to the safety of our blood supply. They're employed in virtually all aspects of collection, processing, distribution, and utilization of blood products. These are driven by both regulatory requirements by the FDA, but also, importantly, voluntary adoption of technologies by blood collectors who see a moral and ethical imperative to improve the quality of the blood supply, and also are responding to patient demand.

Ensuring blood safety obviously involves extensive costs. Here I'd like to mention the survey of 35 community blood centers which spanned a five-year period from 1996 to the year 2000. I was interested to hear that Tim Green's analysis of the cost report data showed no difference between the costs -- I believe he said this -- the cost of

purchasing blood and the annual update factor. That is not what we found.

We found that the cost of producing blood units in this sample rose at an average annual rate of 7 percent between 1996 and the year 2000. This obviously doesn't reflect the recent price increases that have been observed by the American Red Cross this year.

When you break down the different activities of blood centers, collection and testing account for 31 and 21 percent of the cost of producing a unit of blood. The rate of increase for these various activities has been most dramatic for testing and production of blood components which rose by 44 and 57 percent, respectively, over a five-year period.

So that brought us to the producer price index and an examination of whether or not it was a reliable measure of the cost of producing blood. We noticed that there is a dramatic jump btween 1997 and 1999 in the PPI that exists for blood products. That average annual rate is 5.1 percent of icnrease. So rather than this being a one-year spike in the prices of blood, we believe it represents a five-year upward trend in the prices of these blood products. The

trends between the PPI data and our cost data from the 35 blood centers appeared to be roughly similar, although we noted that the prices tended to lag by a least a year the cost trends that we observed.

As mentioned before, since 1996 the PPI for blood and derivatives has been subsumed within the PPI for chemicals. We note that that has risen at a far slower rate than the PPI for blood. I think it was 1.5 percent as compared to 5 percent.

We also compared this trend to the rate of Medicare funding and we found that the 7 percent for our cost data far outpaced the increases in Medicare inpatient input price index, which rose at an average annual rate of only 2.8 percent in this timeframe, and the inpatient hospital update factor increased at an average annual rate of only 0.9 percent. So our cost data was literally seven times greater than the update factors increases during the same time period.

I'll just, to wrap up my comments, mention that there are a number of future technologies that will address other concerns in the blood supply. These are in development. They include nucleic acid testing, pathogen

elimination, additional infectious disease testing, additional processes for interviewing donors and screening them, as well as blood substitute products and enzymatic conversion of red cells. All of these technologies will contribute further to addressing the concerns that we know of today. Obviously that's a moving target. There will be future concerns that result in technology solutions and additional costs in order to ensure the safety of the blood supply.

To conclude, we fully support the use of a separate PPI for blood and blood derivatives. We have not yet considered the second option that was presented by Tim Greene today. We think it's intriguing. It's something we would look at. We don't oppose the use of an add-on for the update factor. Although it is not something we've included in our comments, we will be looking at it between now and November when this commission reconvenes on this issue.

Thank you.

MS. BRODY: I'm here to talk about blood. My name is Lisa Marie Brody. I'm the director of government affairs for America's Blood Centers. America's Blood Centers, or ABC, is a national network of 75 not-for-profit community-

based blood centers which provide nearly half the nation's blood supply to over 3,100 hospitals. America's Blood Centers are located in 45 states and we serve roughly about 125 million people at 450 donation sites.

As non-profit or not-for-profit organizations, America's Blood Centers members pass the cost of collecting, processing, testing, and distributing blood to hospitals. Our members have always prided themselves and worked diligently on providing the highest service at the lowest cost to the hospitals and patients that they serve.

Blood transfusions save over 4 million lives each year. The cost of these transfusions is roughly about $4 billion annually, or less than 2 percent of America's inpatient health care costs. About half of these costs are for providing blood and ensuring its safety, and the other half are hospital costs to ensure blood compatibility and that compatible blood is transfused to the right patient.

While America's blood bill is less than 2 percent of the total, lifesaving transfusions support over 30 percent of all inpatient treatments. This includes organ and marrow transplants, cancer therapies and surgery, trauma and reconstructive surgery.

The blood community along with Congress and the American public demand a safe and available blood supply. In response, new technologies and tests and donor deferrals to improve blood safety are being developed or have already been implemented and recommended by the Food and Drug Administration. These new safety measures, however, are costly and have not been adequately addressed under the current inpatient payment system administered by HCFA. The result is a safe blood supply that has not been paid for.

The majority of blood and blood products are reimbursed under the DRG system. Because the DRGs are re-based only every five years and blood is not included in the yearly marketbasket updates and technology adjustments, the sysetm is inadequate to meet the rapidly changing cost associated with blood safety. The addition of new, costly safe technologies and tests such as leuko-reduction and nucleic acid testing have also not been accounted for in the relatively modest DRG increases over the last five years.

Safety is not the only problem with payment. We are currently experiencing an ever increasing supply problem. Blood is a unique commodity in the sense that it requires people to actually donate. You can't produce

blood. People have to be willing to donate blood. So to make sure that the blood is there when it's needed will require investment of millions of dollars in research, paid advertising, new blood collection infrastructure such as buses and staffing, and other outreach to bring in new donors to replace those lost, and encourage current donors to provide blood more often.

Yet the non-profit industry of the blood-banking community has no capital to reinvest. So our only recourse is to raise fees to hospitals. But because hospitals aren't properly reimbursed for blood we can't really raise our prices. Our hospital customers have traditionally been resistant to pay increased prices for blood.

In the testimony that I provided and we'll be giving to all of you we have attached some timelines which will associate the cost of blood over time and provide relevant data about the different costs and how that cost has been filtered down to the blood-banking community. I won't go into those.

The cost associated with providing a safe and available blood supply was looked at and addressed in the outpatient system. As the outpatient prospective system now

recognizes, new blood safety measures have dramatically increased the cost of blood. Our hope is that the recent steps taken by HCFA to make reimbursement for blood more responsive to cost increases in the outpatient setting will now be replicated in the inpatient setting where the vast majority of blood transfusions take place. America's Blood Centers believes it's really critical that adequate reimbursement and quality of care must be representative and consistent in both settings.

As I stated, HHS through the Food and Drug Administration, agrees with the blood community that these new technologies to further blood safety should be implemented. But the question still remains is how to pay for them. When FDA recommends or implements a new blood safety measure, hospitals often wait two to three years before receiving proportionate reimbursement increases from Medicare and Medicaid. This is not trivial since only 50 percent of all transfusions go to patients covered by Medicare and Medicaid.

In addition, private payers usually follow Medicare's lead on reimbursement levels. Lack of adequate reimbursement for blood products has placed an inordinately

heavy financial burden on blood centers and hospitals.

MR. HACKBARTH: I'm going to interrupt you here. I want to make sure that other people in the audience, perhaps on different topics altogether, have an opportunity. Thanks for your statement. We welcome the contribution.

Other people?

Okay, we adjourn until our November meeting which is when? I didn't mean to ask a difficult question.

DR. ROSS: Good question. The 15th and 16th.

MR. HACKBARTH: The 15th and 16th. Thank you to all the staff for all the work, both on the presentations and the facilities and logistics.

[Whereupon, at 12:12 p.m., the meeting was adjourned.]